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DISADVANTAGED MINORITY HEALTH IMPROVEMENT ACT OF 1989

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

EXAMINING PROPOSED LEGISLATION TO IMPROVE DISADVANTAGED MINORITY HEALTH PROGRAMS

SEPTEMBER 11, 1989

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DISADVANTAGED MINORITY HEALTH IMPROVEMENT ACT OF 1989

MONDAY, SEPTEMBER 11, 1989

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 2:37 p.m., in room SD-430, Dirksen Senate Office Building, Honorable Edward M. Kennedy, chairman of the committee, presiding.

Present: Senators Kennedy, Pell, and Hatch.

The CHAIRMAN. We'll come to order.

I will include as part of the record my complete statement, and given the time constraints and the schedule of the Secretary, we will move right to his testimony, but would first ask whether my colleagues, the Senator from Utah, Senator Hatch, and the Senator from Rhode Island, Senator Pell, would like to make a opening statement.

We are very, very honored to have Secretary Sullivan here. We are dealing with an issue which the Secretary has demonstrated a lifetime of commitment to. We consider his representations today not only the position of the Administration, but we feel that the Administration's position has been enhanced from having the kind of involvement and dedication and insight that the Secretary has demonstrated on so many different issues, but certainly on this one. So we are very honored to have him here. He is someone we have worked with before he was the Secretary and whom we enjoy working with now. I have a great deal of respect for the leadership he is providing in one of the most important agencies of Government, the one that really impacts so many families in so many different ways. So we are indeed honored to have him here.

[Prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

Today I am introducing the Disadvantaged Minority Health Improvement Act of 1989. My good friend and colleague the Honorable Louis Stokes, plans to introduce the same bill in the House of Representatives. This legislation is designed to respond to the need for health promotion and disease prevention programs, and improved access to health care services to reduce the incidence of illnesses that ravage black, Hispanic and other minority communities in this Nation.

Despite the unprecedented explosion in scientific knowledge and the growing capacity of medical science to diagnose, treat, cure and

prevent disease, most of our minority citizens have not benefited fully or equitably from these improvements or from those systems providing essential health care services. The health status of disadvantaged Blacks, Mexican-Americans, Mainland Puerto Ricans, American Indians, and Asian-Pacific Islanders has lagged significantly behind that of the Nation as a whole.

The infant mortality rate among blacks in the United States was 75 percent higher compared to the rate among whites in 1986. Life expectancy at birth has improved for all ethnic and racial groups in this country, except for black males, where it has actually decreased over the past 2 years.

Diabetes is a disease that afflicts more than twice as many Mexican-American males and almost four times as many Mexican-American females than white males and females, respectively. Biliary, stomach, cervical and renal cancers all occur with greater frequency among Hispanics.

The infant mortality rate among natives of the Pacific Basin is 25 percent higher as compared to the U.S. mainland, and Polynesians and Micronesians suffer disproportionately higher rates of diabetes, cardiovascular disease, rheumatic heart disease and suicide.

Amerian Indians and Native Alaskans are another minority subgroup who are victims of unacceptably low health status. Those between the ages of 45 and 64 suffer from diabetes and alcoholic liver disease two and one-half times more than all U.S. citizens. Age specific mortality rates are greater than the rates for all Americans, and deaths from alcohol-related diseases and tuberculosis are fourfold greater.

In 1986, then Secretary of Health and Human Services Margaret Heckler issued the "Report of the Secretary's Task Force on Black Minority Health". Data from this report indicates that minority Americans suffer 60,000 excess deaths each year from heart disease and stroke, homicide and accidents, cancer, infant mortality, alcoholic liver disease, and diabetes.

Since the DHHS Task Force Report in 1986, the impact of AIDS has exacted a heavy and disproportionate toll upon the minority community, thus further increasing the disparity in health between minorities and nonminorities. The most recent statistics indicate that, minorities represent 43 percent of all AIDS cases, which is up from 38 percent in 1984. Minorities represent 73 percent of females with AIDS and 77 percent of children with this dread disease. A recent study from California shows an HIV infection rate among black women giving birth of 12 times that of white women, while the rate among Hispanic women was twice as high. The change in the demographics of AIDS over the last 5 years provides ample evidence of the ease with which a disease can rampage through and devastate a community lacking adequate structures and resources for disease prevention and health promotion. AIDS has quickly become the single most serious health threat to the minority community and must be addressed specifically when considering measures targeted toward improving the health status of minority Americans.

The Disadvantaged Minority Health Improvement Act of 1989 is designed to implement many of the recommendations from the

Task Force Report, with the goal of reducing the tragic loss of life and disability fro preventable disease.

The Office of Minority Health would be authorized with the Office of the Assistant Secretary for Health, to coordinate all activities within DHHS that relate to health promotion, disease prevention, service delivery and research relating to the health of disadvantaged minorities.

The Secretary of Health and Human Services would also be authorized to provide grants and contracts to support new and innovative programs designed to reduce the incidence of specific illnesses and improve the health status of disadvantaged minority Americans.

This legislation will also establish new programs to support health promotion and disease prevention activities focusing on the health problems of American Samoans; scholarships and loans to minority health professions students; and, a loan repayment program for graduates of health professions schools, with the aim of increasing the number of fulltime faculty at predominantly minority health professions schools.

A Pacific Basin Health Services Council would be established to monitor the need for health services and health professions development, and determine priorities for the expenditure of public health funds in the Pacific Basin.

Sixty thousand preventable deaths per year among minorities should not and cannot be tolerated. We have the knowledge and technology—we need to demonstrate the will to make them available to all citizens of the United States, not just the few.

When we as a nation, are seeking to become more competitive in the international economic marketplace, we cannot afford unnecessary and preventable losses to our most basic and important resources . . . our citizens. I sincerely believe that we can ill-afford to not invest significant amounts toward improving the health status of disadvantaged minorities in this country. I look forward to swift consideration of this legislation by the Committee on Labor and Human Resources, and passage by the Senate.

I look forward to testimony from our witnesses today, on the subject of health status disparities between our Nation's minority and non-minority citizens, and the need for greater Federal support to reduce these disparities.

The CHAIRMAN. Senator Hatch?

Senator HATCH. Thank you, Mr. Chairman.

Welcome to the committee, Secretary Sullivan, and of course, all of the other witnesses as well.

I am pleased to participate in this hearing today to examine the current health care status of minorities. It is fitting that we have asked Dr. Sullivan to be the lead witness. Dr. Sullivan has focused much of his public and private service on improving the health of minorities.

Dr. Sullivan, we all admire your skill, your courage, your knowledge, and your longstanding commitment to improving the health of minorities, and we look to your leadership in this area.

I look forward to your testimony today and to working with you to find ways of addressing these very serious problems.

Over the last decade, Americans have continued to improve their health care status, but unfortunately there are still segments of our population that have not caught up. Life expectancy for blacks, for instance, is 69.7 years compared to 76.4 years for whites. Hispanics in the United States have about twice the risk of stomach cancer as other Americans, and American Indians die from injuries almost twice as often as nonminorities.

Many of the causes of these differences can be prevented through improved public education and better coordination of services. Smoking among adult males continues to be about 25 percent higher among blacks than among whites. And while blacks and Hispanics represent about 19 percent of the population, they represent approximately 41 percent of the adult AIDS cases and 76 percent of the pediatric AIDS cases.

We are, however, making some limited progress. During this decade, life expectancy has increased 46 percent faster for blacks than it has for whites, and infant mortality has fallen 62 percent faster for blacks than for whites.

In 1984, the disparity in health among these populations was studied by the Task Force on Black and Minority Health. Recommendations for improvement were identified in six areas: cancer, substance abuse, diabetes, heart disease and stroke, infant mortality and violence. Today, I think we should also add AIDS to this particular list.

The Office of Minority Health was established in 1986 to coordinate Federal efforts at improving minority health care needs. Under Dr. Bowen's leadership, Dr. Herbert Nickens was the first director of this program. So I am pleased to welcome Dr. Nickens here today to share his experience with us and to highlight his new role with the Association of American Medical Colleges.

Today we will also hear from Dr. Jane Delgado, President of the National Coalition of Hispanic Health and Human Services, who is considered a leading expert on the health status of Hispanic Americans. And I am pleased to welcome our colleagues, Congressman Louis Stokes and Congressman Bill Richardson.

Now, as a society, we should not and must not neglect the needs of any segment of our population. We must mobilize our talents, our resources, our knowledge, and, most important, our communities to intensify our efforts to improve the health of minorities.

So, I pledge to work with my colleagues and with Dr. Sullivan to find the ideal course we must set to achieve a healthy society.

Dr. Sullivan, again, welcome. We appreciate your leadership in this area. We look forward to hearing your testimony today, and I for one certainly enjoy working with you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Hatch.

Senator PELL. Thank you, Mr. Chairman.

I am glad and congratulate you for holding this hearing today. I am amongst so many people who have long admired Secretary Sullivan and the principles and stands he has taken in the past. I wish him well and ask his forgiveness if I do not stay through the whole session as I have another commitment.

Thank you.

Secretary SULLIVAN. Thank you.

The CHAIRMAN. Mr. Secretary, we look forward to hearing from you.

STATEMENT OF HON. LOUIS SULLIVAN, M.D., SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Secretary SULLIVAN. Thank you very much, Mr. Chairman, Senator Hatch, Senator Pell.

I very much appreciate this opportunity to appear before you to address the goals of the legislation that is under consideration. Indeed, as you have indicated, this has been an area of great interest of mine over a number of years, not only at the Morehouse School of Medicine where I was for some 13 years, but prior to that time for nine years on the faculty of Boston University School of Medicine as well.

This issue has been of great personal interest and commitment to me. There are a broad range of health conditions which contribute to the disparity in health status in our minority populations including infant mortality, cancer, diabetes, heart disease, chemical dependency, violence and others.

These were highlighted in Secretary Heckler's report in August of 1985 and in June of 1983 were also highlighted in a report from the Association of Minority Health Profession Schools, which was titled, "Blacks in the Health Professions in the Eighties: A National Crisis and a Time for Action". I was involved in the institutions that put that report together, and we held a press conference here in Washington to announce those concerns.

So I am very pleased to have this opportunity to address this issue for you.

My prepared statement I am submitting for the record; I will not go through that because I think that this is not necessary to take that time. But I would like to make a couple of comments, however, for the record.

This legislation from the perspective of one who has worked in the health field for many years, with the focus on minority health, is very important. I congratulate you, Mr. Chairman, for your thoughtful and considered programs for improving the health of our minority communities.

My agenda for the Department of Health and Human Services regarding minority health includes many of the efforts on which this legislation focuses, and I believe that the provisions of your bill will be useful.

I will defer at this time from making a detailed response to the provisions of this legislation except to say that this Administration considers the health of America's minorities to be an important societal focus. Consequently, we are prepared to pursue the programs in this bill as well as to undertake many initiatives of our own.

Our commitment is such that we will consider adjusting our fiscal year 1991 plans to include action at the levels envisioned in this legislation.

The CHAIRMAN. Although at this time you are not prepared to endorse the specific legislative proposals, you have in a very constructive way raised some real concerns, and we are going to work

very closely with you, Senator Hatch and others to try and deal with those. But in terms of the funding, do I understand that you are prepared to say if we are able to work those out, that within the following year, the year of authorization, that you would support the funding for those particular functions?

Secretary SULLIVAN. That is correct, Mr. Chairman. We are prepared——

The CHAIRMAN. And that's the $117 million.

Secretary SULLIVAN. Yes, Mr. Chairman, that is correct.

The CHAIRMAN. All right. Thank you.

Secretary SULLIVAN. There are indeed, as I have indicated, some technical matters in the bill which our agency and your staff will need to address. In addition, I have been advised by the Justice Department that they have some Constitutional concerns with the bill, and they will provide their views to the committee shortly. And I believe, again, those are issues which can be worked out.

As you know, my entire professional life has been dedicated to improving the health of our Nation's minority populations, and I remain grateful to President Bush for placing me in the position in which I can fulfill this goal. I thus look forward to working with the committee in this worthwhile endeavor.

That concludes my remarks, and I look forward to working with you, and I am prepared to respond to any questions you may have.

[Prepared statement of Secretary Sullivan follows:]

PREPARED STATEMENT OF LOUIS W. SULLIVAN, M.D.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, I AM PLEASED TO BE HERE TODAY TO DISCUSS WITH YOU SOME OF OUR EFFORTS TO ADDRESS THE CONSIDERABLE HEALTH DISPARITY BETWEEN BLACKS AND OTHER MINORITIES, AND THE MAJORITY POPULATION. AT THE OUTSET I WISH TO COMPLIMENT YOU ON YOUR BILL, "THE DISADVANTAGED MINORITY HEALTH IMPROVEMENT ACT OF 1989." IT SHOWS A GREAT DEAL OF SENSITIVITY TO THE HEALTH PROBLEMS WHICH MINORITIES FACE. THE PRESIDENT AND I ARE EQUALLY COMMITTED TO CLOSING THIS GAP IN HEALTH STATUS.

AS YOU KNOW, FIVE YEARS AGO, A TASK FORCE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES UNDERTOOK A LANDMARK STUDY TO DOCUMENT THE EXTENT OF THE DISPARITY BETWEEN THE HEALTH STATUS OF MINORITIES AND OTHERS. THE RESULTS ALARMED ALL OF US IN THE MEDICAL COMMUNITY BUT, QUITE FRANKLY, DID NOT SURPRISE THOSE OF US WHO HAD SEEN, ON A FIRST-HAND BASIS, THE IMPACT OF LOWER HEALTH STATUS ON VIRTUALLY EVERY ASPECT OF THE LIVES OF OUR FRIENDS AND FAMILIES, NEIGHBORS, AND PATIENTS. THE TASK FORCE DOCUMENTED THAT 60,000 EXCESS MINORITY DEATHS OCCUR ANNUALLY. MORE THAN 80 PERCENT OF THESE EXCESS DEATHS WERE ASSOCIATED WITH JUST SIX HEALTH PROBLEMS: CANCER, CARDIOVASCULAR DISEASE AND STROKE, CHEMICAL DEPENDENCY, DIABETES, INFANT MORTALITY, AND VIOLENCE. SINCE THE TIME THE TASK FORCE ISSUED ITS REPORT, AIDS HAS BEEN ADDED TO THIS LIST.

THE SECRETARY'S TASK FORCE REPORT TRIGGERED A NUMBER OF SIGNIFICANT ACTIONS WHICH HAVE EXPANDED OVER THE YEARS AND

CONTINUE TODAY. I WANT TO HIGHLIGHT A FEW OF THESE ACTIVITIES, WHICH I THINK ILLUSTRATE AN APPROACH THAT CONTINUES TO PROMISE SUCCESS. IN BRIEF, THAT APPROACH INCLUDES OPERATING PROGRAMS OUT OF THE VARIOUS COMPONENTS OF THE DEPARTMENT, WITH COORDINATION AND TECHNICAL ASSISTANCE FROM THE OFFICE OF MINORITY HEALTH. THIS OFFICE WAS ESTABLISHED SUBSEQUENT TO THE PUBLICATION OF THE TASK FORCE'S REPORT, TO PROVIDE A FOCAL POINT FOR OUR MINORITY HEALTH EFFORTS.

MANY OF OUR PROGRAM EFFORTS ARE FOCUSED ON THE PRIMARY AREAS IDENTIFIED BY THE TASK FORCE. FOR EXAMPLE, IN THE AREA OF CANCER, THE NATIONAL CANCER INSTITUTE HAS TARGETED A NUMBER OF NEW PROGRAMS TOWARD CANCER INTERVENTION IN MINORITY GROUPS. THESE INCLUDE THE MINORITY FIELD PROGRAM, AN INTERVENTION RESEARCH PROGRAM SPECIFICALLY DESIGNED TO ADDRESS BARRIERS TO CANCER PREVENTION AND CONTROL IN BLACK COMMUNITIES NATIONALLY, AND THE NATIONAL BLACK LEADERSHIP INITIATIVE ON CANCER, WHICH SEEKS THE HELP OF THE NATION'S BLACK BUSINESS, CIVIC, AND RELIGIOUS LEADERS IN ACHIEVING CANCER PREVENTION AND CONTROL. BEFORE I WAS APPOINTED HHS SECRETARY, I WAS A MEMBER OF THE NATIONAL CANCER ADVISORY BOARD AND CHAIRED THIS INITIATIVE.

A SECOND MAJOR PROBLEM IDENTIFIED BY THE TASK FORCE WAS INFANT MORTALITY. AS YOU KNOW, THE PRESIDENT HAS DEFINED INFANT MORTALITY AS ONE OF THE NATION'S MOST CRITICAL HEALTH PROBLEMS. THERE IS A SHOCKING DIFFERENCE BETWEEN INFANT MORTALITY RATES IN

MINORITIES VERSUS NON-MINORITIES, AND WE ARE ADDRESSING THIS IN A NUMBER OF WAYS. ONE OF PRESIDENT BUSH'S INITIATIVES RELATED TO REDUCING INFANT MORTALITY INCLUDES RAISING THE MEDICAID ELIGIBILITY FOR PREGNANT WOMEN TO 130 PERCENT OF THE POVERTY LEVEL; REQUIRING STATES TO IMPLEMENT MEDICAID PRESUMPTIVE ELIGIBILITY FOR WOMEN SEEKING PRENATAL CARE; AND PROVIDING ADDITIONAL FUNDS TO THE STATES FOR DEMONSTRATION PROJECTS TO INCREASE THE NUMBER OF SUCCESSFUL PREGNANCIES. OTHER APPROACHES INCLUDE RESEARCH SUPPORTED BY THE NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT THAT FOCUSES SPECIFICALLY ON WAYS TO REDUCE INFANT MORTALITY, WITH SPECIAL EMPHASIS ON INFANT MORTALITY IN MINORITY POPULATIONS.

THE MOST RECENT EXAMPLE OF A HEALTH PROBLEM THAT DISPROPORTIONATELY AFFECTS MINORITIES IS AIDS. WHILE ALL OF OUR HIV AND AIDS EDUCATION AND PREVENTION EFFORTS ARE DESIGNED TO REACH A SPECTRUM OF POPULATIONS AT RISK, WE PLACE SPECIAL EMPHASIS ON HIV RISK AMONG MINORITIES. IN THAT REGARD, THE CENTERS FOR DISEASE CONTROL FUNDS PREVENTION AND EDUCATION ACTIVITIES THROUGH GRANTS TO COMMUNITY-BASED ORGANIZATIONS WHICH HAVE CLOSE RELATIONSHIPS AND ENGAGE IN EFFECTIVE OUTREACH IN MINORITY COMMUNITIES. THIS PROGRAM IS RELATED DIRECTLY, MR. CHAIRMAN, TO A PROPOSAL THAT YOU INCLUDED LAST YEAR IN YOUR COMPREHENSIVE HIV/AIDS LEGISLATION. IN ADDITION, THE NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES RECENTLY HAS BEGUN A PROGRAM OF SUPPORT FOR COMMUNITY-BASED CLINICAL TRIALS, WHICH IS

FOCUSED PARTICULARLY ON INCREASING THE NUMBERS OF MINORITIES, WOMEN, AND CHILDREN WHO CAN HAVE ACCESS TO EXPERIMENTAL THERAPIES THROUGH CONTROLLED CLINICAL TRIALS, WITHOUT TRAVELING TO AN ACADEMIC HEALTH CENTER FAR FROM THEIR HOMES.

RECENTLY, WE HAVE IDENTIFIED AS A MAJOR PUBLIC HEALTH PRIORITY THE VERY SERIOUS PROBLEM OF YOUTH HOMICIDE. IT IS A REMARKABLE AND INCREDIBLY TRAGIC FACT THAT HOMICIDE IS THE LEADING CAUSE OF DEATH FOR BLACK YOUTH IN THE UNITED STATES. I HAVE DIRECTED THE DEPARTMENT TO BEGIN WORKING ON AN INITIATIVE TO ADDRESS THE PUBLIC HEALTH ASPECTS OF YOUTH HOMICIDE. WE ARE PREPARING A PUBLIC INFORMATION CAMPAIGN AND ON-SITE PROJECTS TO HELP OUR YOUNGSTERS FIND ALTERNATIVES TO VIOLENCE IN THE RESOLUTION OF DISPUTES.

THESE ARE JUST A FEW EXAMPLES OF A VERY BROAD ARRAY OF DEPARTMENT PROGRAMS ALREADY UNDERWAY TO ADDRESS IMPROVING THE HEALTH STATUS OF MINORITIES. BECAUSE I WANTED TO FOCUS ON SEVERAL OF THE SPECIFIC CAUSES OF DEATH IDENTIFIED BY THE SECRETARY'S TASK FORCE, THIS LIST WAS VERY SELECTIVE AND DID NOT, FOR EXAMPLE,. INCLUDE DISCUSSION OF ANY OF OUR HEALTH PROFESSIONS TRAINING PROGRAMS, OR MANY OTHER RESEARCH AND PREVENTION ACTIVITIES.

AS SECRETARY OF HEALTH AND HUMAN SERVICES, I AM DETERMINED THAT WE WILL MAKE INROADS IN CONFRONTING MINORITY HEALTH PROBLEMS--AND THAT OUR SUCCESSES WILL PAY BENEFITS IN IMPROVED HEALTH FOR ALL

AMERICANS. TO MAKE THESE INROADS, HOWEVER, WILL REQUIRE THE COOPERATION AND COLLABORATION OF BOTH THE PUBLIC AND THE PRIVATE SECTORS.

ONE OF MY MAJOR CONCERNS IS THE NEED TO DEVELOP LOCALLY TARGETED APPROACHES TO COMPLEMENT OUR OVERALL STRATEGY. WE MUST REMEMBER THAT MINORITY AND OTHER CITIZENS LIVE IN COMMUNITIES FILLED WITH HEALTH RISKS. WE MUST TARGET EFFORTS AT THE LOCAL LEVEL, WHERE MINORITY CITIZENS MAY BE SUBTLE VICTIMS OF ALCOHOL AND TOBACCO ADVERTISING -- AND OVERT VICTIMS OF VIOLENCE AND DRUG ABUSE -- AND WHERE THE PATTERNS OF DAILY LIVING ARE ESTABLISHED.

IT IS AT THE LOCAL LEVEL THAT WE MUST INTERVENE IF WE ARE TO OVERCOME THE LONGSTANDING BURDEN OF ILLNESS IN MINORITY PEOPLE AND THEIR COMMUNITIES. AND THE STRATEGIES MUST BE SPECIFIC AND APPROPRIATE -- BOTH RACIALLY AND CULTURALLY. ABOVE ALL, THEY MUST STRESS DISEASE PREVENTION AND HEALTH PROMOTION.

I ALREADY HAVE ASKED THE ASSISTANT SECRETARY FOR HEALTH, DR. JAMES MASON, AND THE DIRECTOR OF THE OFFICE OF MINORITY HEALTH, DR. WILLIAM ROBINSON, TO BEGIN IMMEDIATELY TO DEVELOP AND IMPLEMENT A PLAN TO ADDRESS THE DISPARITY IN MINORITY HEALTH STATUS, WITH A FOCUS ON LOCAL LEVEL INTERVENTION. THIS EFFORT WILL INVOLVE A BROAD SPECTRUM OF ORGANIZATIONS AND INSTITUTIONS, AND WILL TARGET MAJOR HEALTH PROBLEMS FACED BY MINORITY POPULATIONS.

THE INITIAL FOCUS OF THIS EFFORT WILL BE TO REVIEW THE UTILIZATION OF EXISTING RESOURCES TO ENSURE ITS APPROPRIATENESS AND DIRECTION. TO THE DEGREE THAT ADDITIONAL RESOURCES ARE REQUIRED, RE-PRIORITIZATION AND RE-DIRECTION OF EXISTING RESOURCES WILL BE GIVEN PRIMARY CONSIDERATION.

WE HAVE NOT MADE THE PROGRESS WE DESIRE TOWARD CLOSING THE GAP BETWEEN THE HEALTH STATUS OF MINORITIES AND THAT OF THE MAJORITY POPUOLATION. INDEED, IN SOME AREAS, SUCH AS AIDS AND HOMICIDE, WE FACE THE PROSPECT OF ACTUALLY LOSING GROUND. BUT THIS IS NOT A REASON FOR US TO GIVE UP. I CAN ASSURE YOU THAT I AM ABSOLUTELY DEDICATED TO LISTENING TO THE PROBLEMS, TO UNDERSTANDING WHERE WE NEED TO FOCUS GREATER ATENTION, AND TO TAKING WHATEVER ACTION IS IN MY POWER TO TAKE TO ADDRESS THOSE PROBLEMS. AS FAR AS MY BUDGET PRIORITIES ARE CONCERNED, REDUCING THE HEALTH STATUS DISPARITY IS AT THE VERY TOP OF MY LIST.

<u>COMMENTS ON THE DISADVANTAGED MINORITY HEALTH LEGISLATION</u>

MR. CHAIRMAN, REGARDING YOUR LEGISLATION: FROM THE PERSPECTIVE ON ONE WHO HAS WORKED IN THE HEALTH FIELD FOR MANY YEARS, AND WHOSE FOCUS HAS BEEN PRIMARILY ON MINORITY HEALTH, I WANT TO CONGRATULATE YOU ON THOUGHTFUL AND CONSIDERED PROPOSALS FOR IMPROVING THE HEALTH OF OUR MINORITY COMMUNITIES. MY AGENDA FOR THE DEPARTMENT REGARDING MINORITY HEALTH IMPROVEMENT INCLUDES

MANY OF THE EFFORTS ON WHICH THIS LEGISLATION FOCUSES, AND I BELIEVE THE PROVISIONS OF YOUR BILL WILL BE USEFUL.

I WILL DEFER, AT THIS TIME, MAKING A DETAILED RESPONSE TO THE PROVISIONS OF THIS LEGISLATION EXCEPT TO SAY THAT THIS ADMINISTRATION CONSIDERS THE HEALTH OF AMERICA'S MINORITIES TO BE AN IMPORTANT SECRETARIAL FOCUS. CONSEQUENTLY, WE ARE PREPARED TO PURSUE THE PROGRAMS OF THIS BILL AS WELL AS UNDERTAKE MANY OF OUR OWN. OUR COMMITMENT IS SUCH THAT WE WILL CONSIDER ADJUSTING OUR FISCAL YEAR 1991 PLANS TO INCLUDE ACTION AT THE LEVELS ENVISIONED BY THIS LEGISLATION.

WHILE THERE ARE SOME TECHNICAL MATTERS IN THIS BILL WHICH OUR AGENCY AND YOUR STAFF WILL HAVE TO ADDRESS, I AM CONFIDENT WE CAN REACH AGREEMENT ON HOW BEST TO ADDRESS MINORITY HEALTH PROBLEMS. IN ADDITION, I AM ADVISED BY THE DEPARTMENT OF JUSTICE THAT THEY HAVE CONSTITUTIONAL CONCERNS ABOUT THE BILL AND WILL PROVIDE THEIR VIEWS TO THE COMMITTEE SHORTLY.

AS YOU KNOW, MR. CHAIRMAN, MY ENTIRE PROFESSIONAL LIFE HAS BEEN DEDICATED TO IMPROVING THE HEALTH OF MINORITY POPULATIONS. I REMAIN GRATEFUL TO PRESIDENT BUSH FOR PLACING ME IN A POSITION IN WHICH I CAN FULFILL THIS GOAL. I VERY MUCH LOOK FORWARD TO WORKING WITH YOUR COMMITTEE IN THIS WORTHWHILE ENDEAVOR.

MR. CHAIRMAN, THIS CONCLUDES MY PREPARED REMARKS. THANK YOU FOR THE OPPORTUNITY TO PRESENT MY VIEWS ON THIS MOST IMPORTANT SUBJECT. I WILL BE PLEASED TO ANSWER ANY QUESTIONS YOU MAY HAVE.

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The CHAIRMAN. Well, thank you very much. In a very brief and concise way, you have said about all that we'd like to have you say with the exception that you might have embraced the bill.

I might just take a few moments to go on to related matters. We are talking about funding recommendations for fiscal year 1991 that, and I understand that that is a positive response from the Administration, but that we have some areas of difference. We pointed out that our concern is that we do not diversify programs so completely that we lose the focus and attention on this subject matter which we think deserves some special attention.

But we are convinced, Dr. Sullivan, by your record and commitment that obviously, you have a strong common commitment, as all of us do, in trying to work these matters out. And although I don't quite see the form and shape of it this afternoon, I am convinced that those matters can be worked out. The fact that the Administration is prepared to support this funding is sufficiently powerful that we had better not fail to do so.

Second, the other issues dealing with the Constitutional questions on the set-asides are legitimate issues and need to be addressed. I think we obviously have a common interest in working those out.

So we want to work very closely with you in being able to do it. Another point that you made is that the Administration has additional initiatives of its own, and we want to indicate to you that we welcome those as we move on through the legislative process, and we invite those recommendations that the Administration would have in this area that you think can help us deal with the challenge. I know that you have given a great deal of thought to this question.

Let me just take a few moments, if I could. With regard to the loan forgiveness program to encourage health care professionals to join minority institutions, to develop and strengthen the faculty, there are many different factors that impact the development and strengthening of faculty. You formerly served as the dean at an important university. Would you just comment briefly about the kinds of things you think are most useful in attracting faculty?

Secretary SULLIVAN. Yes. I believe that is a very important initiative in the legislation because as you know, less than 2 percent of the medical school faculties in the country are black. We need to have more black faculty both in minority institutions as well as in majority institutions for the following reasons: one, such faculties serve as role models for students enrolled as well as applicants to the institutions; second, they help to address the health issues of the minority community, I think, in a very acute way; third, many of these medical schools are affiliated with charity hospitals in various communities which are the major teaching outlets for a number of medical schools. I have noted in the case of my own institution—and I suspect that this is transferable elsewhere—that having significant numbers of minority faculty not only helps in working with the patients cared for by that institution, but it also helps to sensitize the hospital staffs in dealing with those individuals.

Finally, the referral patterns for the hospitals are helped as well. That is, the minority physicians working in the community will

feel their patients as well as their concerns are given adequate consideration so that the communication between the academic medical center and the referring physicians and clinics, I think, is enhanced.

So I think that improving minority faculty is indeed a very important initiative in the bill that we would like to see go forward.

The CHAIRMAN. Another phenomenon is that we probably have enough physicians in the country, but they are not practicing in the right places—we continue to have underserved areas not only in rural communities but also in the inner cities.

We have moved back in recent years, through the National Health Service Corps, to attract people into those areas with some loan forgiveness. Do you have any other suggestions for us about what might be done to attract individuals into those underserved areas?

Secretary SULLIVAN. Well, one feature of the physician payment reform legislation that is working its way through the Congress now that we believe will help—although we certainly do not have the final answer—is improving the reimbursement rates for physicians in medically underserved areas as well as the primary feature of that legislation which will give greater reimbursement to physicians in the primary care specialties.

As you know, we are confronted in our Nation with the high costs of medical care and the rapid escalation in cost, but this has been driven in large measure by the procedurally-based specialties. That legislation, of course, addresses giving greater recognition and reimbursement for primary care physicians because as you know, we have now the reverse in our physician population that existed in the Thirties and Forties. So certainly efforts to change the reimbursement patterns for physicians, improving the reimbursement for primary care, and the further possible bonus payments to physicians who work in medically underserved areas will help.

Now, I am sure that there will be other initiatives, but those are two that we have identified thus far.

The CHAIRMAN. Well, I hope the Administration will listen to those wise words of counsel. There are a number of different factors in terms of getting people into underserved areas, but you have really put your finger right on one of the very, very important and essential ones. There have been too few administrations, Democrat as well as Republican, willing to really bit into that apple and take on that hot potato, and you have really targeted it.

Finally, you might take a look at the various educational materials now being provided by community-based organizations relating to the AIDS issue. During the recent break, I had a chance to visit a number of the neighborhood centers, talking to those who are really working on the front lines in terms of education programs. They have some concerns about some of the educational material that is being developed, whether it is really as effective as it might be. Perhaps someone on your staff might take a look at it and give you a report on it, and get your own insight and evaluation of that.

In the time I have been in the Senate, I do not know of any Cabinet officer who has come up on a relatively new initiative and been able to get OMB in line the way you have, particularly with the

kinds of shortages we have at this time. You deserve to be commended for many reasons, but that is one that should not be lost.

Thank you.

Secretary SULLIVAN. Thank you.

The CHAIRMAN. Senator Hatch?

Senator HATCH. Senator Kennedy is introducing this legislation tomorrow to expand the Federal Government's role in educating minority health care professionals.

As I understand it, the Justice Department has raised some Constitutional issues with regard to this bill. Would you mind elaborating upon these concerns and just give us a little bit there?

Secretary SULLIVAN. Yes. The question that has been raised by the Justice Department in our discussions with them thus far is the Constitutionality of the set-asides as they have been articulated in the bill thus far—that is, that institutions would be eligible if they have a certain makeup of their class size, that is, 50 percent or greater.

I think that none of us are in disagreement with the intent of the legislation, that is, to increase the number of minority physicians. But I think there is a question as to whether that mechanism or that provision really would stand judicial scrutiny.

We have not received the detailed analysis from the Justice Department, but this is what has been raised by them.

Senator HATCH. I am going to ask you to do this, Dr. Sullivan. If they think there are Constitutional infirmities in this legislation, then I would ask them to do more than just suggest that there are. I would like them to help us to meet the goals of Senator Kennedy by suggesting language that would be appropriate and will get us there just as well as the language in the bill.

I am concerned about all these matters involving Constitutionality, but I also think that we have to be concerned about minority health. We certainly have to create the opportunity for more minority doctors and health professionals.

So I share the same goals that Senator Kennedy does, and I would like to see us enlist their help. If you will say—look, we don't want to have you attorneys telling us what you know; we want you to say this is the way it can be done. And, let's see if they can come up with a way that will help us to reach these same goals that Senator Kennedy and others have. I think that would please you, and it would please me. And, in the end we'll probably have a pretty good bill here.

Secretary SULLIVAN. I'll be pleased to do so.

Senator HATCH. Well, given that Hispanic communities do not have a network comparable in size, history and resources as that provided by the historically black medical colleges, what is being done by the Department to support and provide services through the network of Hispanic community-based organizations? Are we going to do something there as well?

Secretary SULLIVAN. Yes. We are indeed very committed to improving the health of all minorities, Senator Hatch——

Senator HATCH. I know you are.

Secretary SULLIVAN [continuing]. Not only the black community but the Hispanic community as well. And this also includes our efforts to bring into the Department in responsible positions mem-

bers of the Hispanic community. So we will certainly work to be sure that we are receiving and are sensitive to the concerns from the Hispanic organizations.

Senator HATCH. And other minorities as well.

Secretary SULLIVAN. Yes.

Senator HATCH. We have a huge Indian population in Utah, and I am concerned about Asians and every other minority that we have in this society.

In that regard would you consider, Dr. Sullivan, expanding the data collection and reporting published annually in the "Health U.S." to include information on the health status of Hispanics in our country?

Secretary SULLIVAN. Yes, we would certainly do so. What I would want to do is make sure that in making such a commitment, we have the capability of doing that, because I do know that during the time of the report of the Task Force on Minority Health, when Secretary Heckler was in charge of the Department, the difficulties that the task forces had at that time was that the data for Hispanic communities was not readily available. But certainly to the degree that we can do that, I am committed to doing that.

Secretary HATCH. Thank you.

Senator Kennedy, if we can accommodate these concerns that the Secretary has raised, I am very interested in cosponsoring your bill. I hope that this hearing today—I can't stay for the complete hearing because of other commitments—but I am hoping that if we can accommodate your concerns and we can do it in an appropriate way, then I would like to become a principal cosponsor on this bill and do everything I can to see that it gets through both Houses of Congress.

We appreciate your testimony here today, Dr. Sullivan. I see much need for this type of legislation. This isn't the first thing we have done, but it is very important, and I want to commend the distinguished chairman for taking the lead in this type of legislation because it is long overdue. I also want to commend you, Dr. Sullivan, for being so willing to come up on short notice and to give the valuable testimony you have, and of course, for your efforts to try and see that we have the funding as well. I want to compliment you for that.

Secretary SULLIVAN. Thank you very much. We look forward to working with you.

The CHAIRMAN. Mr. Secretary, I join in the request of the Senator from Utah about how we might be able to deal with some of those concerns and language that you might have. And I want to indicate publicly that we'll work very closely with Senator Hatch. We have worked very closely together on many different issues, the most recent on the Americans with Disabilities Act. We look forward to working with him and with you, and I am convinced we will be able to develop legislation which all of us can support. That is certainly our intention.

We want to thank you very much for your continued leadership in so many areas involving health and your agency.

Thank you very much.

Secretary SULLIVAN. Thank you very much. It is a pleasure to have testified before you.

Senator HATCH. Good to see you.

The CHAIRMAN. We are happy to hear next from two good friends who have come over here from the House of Representatives, the honorable Louis Stokes and the honorable Bill Richardson.

Congressman Stokes will be the principal sponsor of this legislation in the House of Representatives. He has served in Congress for many years and has been a tireless advocate for these issues when many others were not, and this legislation in a very important way bears his imprint. We are very glad and appreciative of his willingness to come over.

And of course, Bill Richardson, who has been the head of the Hispanic Caucus, has a knowledge and understanding and awareness of these issues in a very, very special way. I have had the good chance to visit with him on health care concerns for Hispanic individuals, and he has a keen insight.

So we are very fortunate to have both these members of Congress come over here, and we look forward to hearing Congressman Stokes.

Senator HATCH. Mr. Chairman, may I just say one thing?

The CHAIRMAN. Senator Hatch.

Senator HATCH. I have to leave, and I hate to leave with both of you here. But I will read the testimony that each of you give, and I will commit to you that I will do my very best to help with this legislation and help to get it through. So we appreciate the leadership both of you exhibit not only on this issue but on so many others as well.

So if you will forgive me for having to leave.

Mr. STOKES. Sure, we understand. Thank you very much, Senator Hatch. We appreciate it.

Mr. RICHARDSON. Thanks for your leadership on these issues, too, Senator.

The CHAIRMAN. Mr. Stokes?

STATEMENTS OF HON. LOUIS STOKES, A REPRESENTATIVE IN CONGRESS, FROM THE STATE OF OHIO, AND HON. BILL RICHARDSON, A REPRESENTATIVE IN CONGRESS, FROM THE STATE OF NEW MEXICO

Mr. STOKES. Thank you, Mr. Chairman, Senator Kennedy. It is indeed a real honor to appear here before you and your committee this afternoon and to have the privilege of testifying in support of the legislation that you are introducing here.

I want to personally commend you for the leadership that you are showing here today in this area as you have for so many years in matters related to minority communities throughout America.

I also am privileged to appear here with my very distinguished colleague, Bill Richardson, who represents the Hispanic Caucus in the House and whose leadership has been essential to all of us in these types of issues.

Mr. Chairman, as Chairman of the Congressional Black Caucus Health Braintrust, I have had the responsibility of establishing and overseeing many of the health policies supported by the Caucus. I am proud to say that my colleagues and I have been some of the

most vocal and ardent advocates for quality health care for all Americans, especially the poor, minorities, children and the elderly.

Our assessment of the problem is oftentimes different from the mainstream and therefore calls for different solutions to addressing them.

The position has been especially significant in recent years since the release of the 1985 report of the Secretary's Task Force on Black and Minority Health. This report tells us that despite all of our efforts and that of others, we have not been able to prevent the high and growing rate of disease and death in minority America. The reality is that there is a health crisis in minority America. The fact was quantified in the Secretary's task force report which found that blacks and other minorities are victimized by diseases and die at higher rates than white Americans.

Last year, a dramatic worsening of this condition was exemplified by a two-year decline in black life expectancy at a time when white life expectancy has continued to increase. Looking at the health of black Americans, it is disturbing to see in the Secretary's report that black males can expect to live six fewer years than white males; that for those blacks who do live longer lives, they suffer a disproportionately higher incidence of hypertensive diseases, diabetes, cancer and glaucoma; that one out of every four blacks has high blood pressure compared to one out of every seven whites; that black males aged 45 to 65 have a 41 percent higher death rate from heart disease than white males; that the rate for black females is more than twice as high than for white females; that cancer mortality rates for blacks have increased by 265 percent over the past 25 years, while for whites, that increase has been only 5 percent.

Not only are blacks fighting these diseases, but black babies are twice as likely to die in the first year of life than white babies, a rate equal to the infant mortality rate of many Third World countries. In essence, black Americans 'lives are being snuffed out not only at the outset, but in the most productive years of their lives.

Add to this bleak picture the problem of AIDS—which, by the way, was not one of the six major health disparities in the task force report. Yet as you know, blacks, who comprise 12 percent of the U.S. population, constitute 27 percent of all AIDS cases. Moreover, 52 percent of AIDS cases among children under 13 years of age in the United States have occurred among blacks. For black females, this figure is now 52 percent.

This chilling depiction of black health is just as grim for our fellow Hispanic and other minority Americans. These statistics underscore the need for strong leadership from the top to fight the serious health crisis and the need for an aggressive plan of action to implement the task force recommendations in order to overcome this disparity. The fact that since the release of the task force report, black life expectancy has declined leads us to the conclusion that we as a Nation have not done either of these.

As a member of the Labor-Health and Human Services-Education Appropriations Subcommittee, I have tried to imprint upon our deliberations a focus on minority health. One such example is the Office of Minority Health, the focal point for the implementa-

tion of the task force report. It is an office that could potentially make a significant contribution toward reducing the disparity. However, it is not yet receiving sufficient resources and support to accomplish this goal. With an appropriation of $3 million and 11 staff positions in 1989, it is underfunded and understaffed. I also feel that this office could take a greater coordinative role in the Department's efforts in the area of minority health.

Mr. Chairman, in the interest of time, I will ask that my entire statement be made a part of the record, and I will pause at this point and be open for any questions that you may have. I would be glad to yield at this time to my distinguished colleague, Congressman Richardson.

[Prepared statement of Mr. Stokes follows:]

PREPARED STATEMENT OF HON. LOUIS STOKES

GOOD MORNING MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE.

I APPRECIATE THIS OPPORTUNITY TO SPEAK TO THE NEED FOR LEGISLATION SUCH AS THAT WHICH I WILL BE INTRODUCING IN THE HOUSE AND SENATOR KENNEDY HAS INTRODUCED IN THE SENATE TO IMPROVE THE HEALTH OF MINORITY AMERICA.

AS CHAIRMAN OF THE CONGRESSIONAL BLACK CAUCUS HEALTH BRAINTRUST, I HAVE HAD THE RESPONSIBILITY OF ESTABLISHING AND OVERSEEING MANY OF THE HEALTH POLICIES SUPPORTED BY THE CAUCUS. I AM PROUD TO SAY THAT MY COLLEAGUES AND I HAVE BEEN SOME OF THE MOST VOCAL AND ARDENT ADVOCATES FOR QUALITY HEALTH CARE FOR ALL AMERICANS, ESPECIALLY THE POOR, MINORITIES, CHILDREN, AND THE ELDERLY. OUR ASSESSMENT OF THE PROBLEM HAS OFTENTIMES DIFFERED FROM THE MAINSTREAM, AND

THEREFORE CALLED FOR DIFFERENT SOLUTIONS TO ADDRESSING THEM.

THIS POSITION HAS BEEN ESPECIALLY SIGNIFICANT IN RECENT YEARS SINCE THE RELEASE OF THE 1985 REPORT OF THE SECRETARY'S TASK FORCE ON BLACK AND MINORITY HEALTH. THIS REPORT TELLS US THAT DESPITE ALL OF OUR EFFORTS -- AND THAT OF OTHERS -- WE HAVE NOT BEEN ABLE TO PREVENT THE HIGH AND GROWING RATE OF DISEASE AND DEATH IN MINORITY AMERICA. THE REALITY IS THAT THERE IS A HEALTH CRISIS IN MINORITY AMERICA.

THIS FACT WAS QUANTIFIED IN THE SECRETARY'S TASK FORCE REPORT WHICH FOUND THAT BLACKS AND OTHER MINORITIES ARE VICTIMIZED BY DISEASES AND DIE AT HIGHER RATES THAN WHITE AMERICANS. LAST YEAR, A DRAMATIC WORSENING OF THIS CONDITION WAS EXEMPLIFIED BY A TWO-YEAR DECLINE IN BLACK LIFE

EXPECTANCY AT A TIME WHEN WHITE LIFE EXPECTANCY HAS CONTINUED TO INCREASE.

LOOKING AT THE HEALTH OF BLACK AMERICANS, IT IS DISTURBING TO SEE IN THE SECRETARY'S REPORT THAT BLACK MALES CAN EXPECT TO LIVE 6 FEWER YEARS THAN WHITE MALES; THAT FOR THOSE BLACKS WHO DO LIVE LONGER LIVES, THEY SUFFER A DISPROPORTIONATELY HIGHER INCIDENCE OF HYPERTENSIVE DISEASES, DIABETES, CANCER AND GLAUCOMA; THAT ONE OUT OF EVERY FOUR BLACKS HAS HIGH BLOOD PRESSURE COMPARED TO ONE OUT OF EVERY SEVEN WHITES; THAT BLACK MALES AGED 45-65 HAVE A 41% HIGHER DEATH RATE FROM HEART DISEASE THAN WHITE MALES, AND THAT THE RATE FOR BLACK FEMALES IS MORE THAN TWICE AS HIGH FOR WHITE FEMALES; THAT CANCER MORTALITY RATES FOR BLACKS HAVE

INCREASED BY 265% OVER THE PAST 25 YEARS, WHILE FOR WHITES THAT INCREASE HAS BEEN ONLY 5%.

NOT ONLY ARE BLACKS FIGHTING THESE DISEASES, BUT BLACK BABIES ARE TWICE AS LIKELY TO DIE IN THE FIRST YEAR OF LIFE THAN WHITE BABIES, A RATE EQUAL TO THE INFANT MORTALITY RATE OF MANY THIRD WORLD NATIONS. IN ESSENCE, BLACK AMERICANS' LIVES ARE BEING SNUFFED OUT NOT ONLY AT THE ONSET, BUT IN THE MOST PRODUCTIVE YEARS OF LIFE.

ADD TO THIS BLEAK PICTURE THE PROBLEM OF AIDS -- WHICH BY THE WAY WAS NOT ONE OF THE SIX MAJOR HEALTH DISPARITIES IN THE TASK FORCE REPORT. YET, AS YOU KNOW, BLACKS WHO COMPRISE 12% OF THE U.S. POPULATION CONSTITUTE 27% OF ALL AIDS CASES. MOREOVER, 52% OF AIDS CASES AMONG CHILDREN UNDER 13 YEARS OLD

IN THE UNITED STATES HAVE OCCURRED AMONG BLACKS; FOR BLACK FEMALES THIS FIGURE IS 52%.

THIS CHILLING DEPICTION OF BLACK HEALTH IS JUST AS GRIM FOR OUR FELLOW HISPANIC AND OTHER MINORITY AMERICANS.

THESE STATISTICS UNDERSCORE THE NEED FOR STRONG LEADERSHIP FROM THE TOP TO FIGHT THIS SERIOUS HEALTH CRISIS AND THE NEED FOR AN AGGRESSIVE PLAN OF ACTION TO IMPLEMENT THE TASK FORCE RECOMMENDATIONS IN ORDER TO OVERCOME THIS DISPARITY. THE FACT THAT SINCE THE RELEASE OF THE TASK FORCE REPORT BLACK LIFE EXPECTANCY HAS DECLINED LEADS US TO THE CONCLUSION THAT WE AS A NATION HAVE NOT DONE EITHER OF THESE.

AS A MEMBER OF THE LABOR-HEALTH AND HUMAN SERVICES-EDUCATION APPROPRIATIONS SUBCOMMITTEE, I HAVE TRIED TO

IMPRINT UPON OUR DELIBERATIONS A FOCUS ON MINORITY HEALTH.

ONE SUCH EXAMPLE IS THE OFFICE OF MINORITY HEALTH, THE FOCAL POINT FOR THE IMPLEMENTATION OF THE TASK FORCE REPORT. IT IS AN OFFICE THAT COULD POTENTIALLY MAKE A SIGNIFICANT CONTRIBUTION TOWARD REDUCING THE DISPARITY. HOWEVER, IT IS ~~HAS~~ NOT YET RECEIVED SUFFICIENT RESOURCES AND SUPPORT TO ACCOMPLISH THIS GOAL. WITH AN APPROPRIATION OF $3 MILLION AND 11 STAFF POSITIONS IN 1989, IT IS UNDERFUNDED AND UNDERSTAFFED. I ALSO FEEL THAT THIS OFFICE COULD TAKE A GREATER COORDINATIVE ROLE IN THE DEPARTMENT'S EFFORTS IN THE AREA OF MINORITY HEALTH.

THROUGH THE APPROPRIATIONS COMMITTEE, THIS YEAR'S HOUSE BILL CONTAINS -- AS A RESULT OF AN AMENDMENT I INTRODUCED --

ADDITIONAL FUNDING FOR THIS OFFICE, WHICH WOULD BRING FUNDING TO $4.5 MILLION AND STAFFING TO 15 STAFF POSITIONS. HOWEVER, A PERMANENT STATUTORY AUTHORITY WOULD BE USEFUL TO ESTABLISH A GREATER ROLE FOR THE OFFICE AND TO GUIDE THE APPROPRIATIONS COMMITTEE IN PROVIDING IT WITH SUFFICIENT RESOURCES.

ANOTHER AREA THAT COULD MAKE A SIGNIFICANT DIFFERENCE IN DECREASING THE HEALTH STATUS DISPARITY IS TO INCREASE THE NUMBER OF MINORITIES INVOLVED IN BIOMEDICAL RESEARCH AND THE HEALTH PROFESSIONS. MINORITY SCIENCES AND HEALTH PROFESSIONALS SHOULD BE AVAILABLE TO ADDRESS THE HEALTH NEEDS OF THE MINORITY COMMUNITY, AS WELL AS THAT OF THE OVERALL POPULATION. THE SECRETARY'S TASK FORCE CAME TO THE SAME CONCLUSION THAT THE EXISTING HEALTH CARE SYSTEM IS IN NEED OF

MORE MINORITY HEALTH CARE PROFESSIONALS TO OFFSET THE HEALTH CRISIS CONFRONTING MINORITIES. IN ADDITION, IT IS CRUCIAL THAT WE ENSURE THAT MINORITIES ARE INVOLVED IN POLICY DECISIONS THAT IMPACT UPON HEALTH STATUS.

AS A RESULT OF THE LEGISLATIVE EFFORTS IN THE EARLY 1970'S BY FORMER SENATOR BROOKE AND MYSELF, THE MINORITY ACCESS TO RESEARCH CAREERS PROGRAM (MARC) AND THE MINORITY BIOMEDICAL RESEARCH SUPPORT PROGRAM (MBRS) WERE ESTABLISHED AT THE NATIONAL INSTITUTES OF HEALTH. THESE PROGRAMS ARE INTENDED TO ATTRACT MINORITY COLLEGE STUDENTS INTO RESEARCH CAREERS. RECOGNIZING THAT WE MUST ATTRACT STUDENTS INTO SCIENCE AT AN EARLIER AGE, AN ADDITIONAL PROGRAM, THE MINORITY HIGH SCHOOL STUDENT RESEARCH APPRENTICE PROGRAM, WAS

ESTABLISHED AT NIH IN 1980.

THE NEWEST PROGRAM, THE RESEARCH CENTERS IN MINORITY INSTITUTIONS PROGRAM, A PROGRAM DESIGNED TO BUILD THE RESEARCH CAPACITY OF MINORITY INSTITUTIONS, WAS INITIATED AT NIH BY THE ACTION OF MYSELF AND OTHER MEMBERS OF THE APPROPRIATIONS COMMITTEE. CURRENTLY MINORITY PROGRAMS NOW TOTAL OVER $50 MILLION. HOWEVER, THIS REPRESENTS LESS THAN 1% OF THE TOTAL NIH BUDGET. ALTHOUGH NIH HAS DEVELOPED A NUMBER OF RESEARCH INITIATIVES TARGETED TOWARD MINORITIES, MINORITY RESEARCHERS BY AND LARGE HAVE NOT BEEN PARTICIPATING IN THESE PROGRAMS.

WITH REGARD TO RECRUITMENT OF MINORITIES INTO THE HEALTH PROFESSIONS, THE APPROPRIATIONS COMMITTEE HAS TRIED TO

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PROTECT PROGRAMS WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES THAT PROVIDE SUPPORT TO DISADVANTAGED STUDENTS SEEKING CAREERS IN THE HEALTH PROFESSIONS. WERE IT NOT FOR THE ACTIONS OF THE APPROPRIATIONS COMMITTEE, EXCEPTIONAL NEED SCHOLARSHIPS, EXCELLENCE IN MINORITY HEALTH EDUCATION CENTERS PROGRAMS, AND THE HEALTH CAREERS OPPORTUNITIES PROGRAMS WOULD HAVE BEEN ELIMINATED BY THE REAGAN ADMINISTRATION. THESE EFFORTS, HOWEVER, ARE STILL NOT ENOUGH TO GUARANTEE A SUFFICIENT POOL OF MINORITY HEALTH CARE PROFESSIONALS TO OFFSET THE EXISTING MINORITY HEALTH CRISIS.

SO AS YOU CAN SEE, THERE HAS BEEN TO SOME DEGREE POSITIVE EFFORTS BY THE CONGRESS TO RESPOND TO HEALTH INITIATIVES TO IMPROVE THE HEALTH STATUS OF MINORITY

AMERICANS.

WE HAVE TO WORK HARDER THOUGH IN THE FUTURE IF WE ARE TO MAKE ANY MEANINGFUL DENT IN THIS PROBLEM. THIS TAKES ON A SPECIAL CONSEQUENCE WHEN WE LOOK AT THE LATEST STATISTICS FROM THE BUREAU OF CENSUS FOR FUTURE DEMOGRAPHIC TRENDS IN THE UNITED STATES. THESE FIGURES INDICATE THAT BY THE YEAR 2000, BLACKS AND OTHER MINORITIES WILL COMPRISE ONE-THIRD OF NEW ENTRANTS INTO THE U.S. WORKFORCE; TWICE THEIR CURRENT SHARE OF THE WORKFORCE. MOREOVER, BY THE YEAR 2020, 39% OF ALL AMERICANS WORKERS WILL BE MINORITY.

WHAT THIS SAYS IS THAT WE MUST RECOGNIZE THAT THIS HEALTH CRISIS IN BLACK AND MINORITY AMERICA HAS MAJOR RAMIFICATIONS FOR ALL SEGMENTS OF OUR NATION. THESE REAL AND

DIFFICULT ISSUES FACE US AT THE FEDERAL, STATE AND LOCAL LEVEL, AND IN THE PRIVATE AND PUBLIC SECTORS OF OUR SOCIETY.

THE PICTURE BEING PAINTED HERE TODAY I KNOW IS VERY BLEAK. HOWEVER, I AM CONFIDENT THAT WITH YOUR SUPPORT WE CAN MEET THIS ENORMOUS CHALLENGE. WE HAVE THE TECHNOLOGY AND RESOURCES TO DIAGNOSE, TREAT AND, MOST IMPORTANTLY, PREVENT SO MANY OF THE DISEASES AFFECTING BLACK AMERICANS. LET'S TAKE THE FIRST STEP IN MEETING THIS CHALLENGE. FOR IF WE CAN SOLVE THE HEALTH PROBLEMS OF BLACK AND MINORITY AMERICA, WE CAN SOLVE THE PROBLEMS OF ALL AMERICANS.

The CHAIRMAN. Mr. Richardson?

Mr. RICHARDSON. Thank you, Mr. Chairman, and thank you, Congressman Stokes. And again to Senator Kennedy, you are championing something that your record is most distinguished in, and Senator, thank you for probably making the legislation that Congressman Stokes has been pushing for four years a reality because now, with your support here in the Senate, it is not just a one-House bill; it is now a substantial effort that, coupled with the Secretary's statement earlier, which I sensed was an endorsement—close to it, anyway—that we may have some significant legislation.

Senator, I am representing the Congressional Hispanic Caucus. I have a letter I'd like to submit for the record from Jaime Fuster. And I would also like to ask unanimous consent to insert my entire statement in the record. I'd like to very briefly summarize, because I know you have a number of important witnesses following Congressman Stokes and myself.

The CHAIRMAN. We will include all the statements in their entirety in the record as if read.

Mr. RICHARDSON. The issue of poverty and the continuing lack of access to basic human resources remain a persistent fact of life for millions of Hispanics, and I think it is very clear that the Hispanic community is the fastest-growing minority in this country and will, shortly after the year 2000, be the largest minority in the United States.

We have in this Census probably a projection of 30 million Hispanics in this country, and I think the statistics bear out that we have tremendous growth in this Hispanic community.

One of the most significant barriers is the pervasive lack of access to health care services. One in four Hispanics, or 21.7 percent, has no form of health insurance, a rate that is almost three times that of nonHispanic whites. Not surprisingly, the lack of health insurance means that Hispanics are significantly restricted in their access to our Nation's health care system.

One in three Hispanics has no regular source of health care—a rate that is almost twice that of nonHispanic whites. The result is delayed health care, prolonged illnesses, and a real loss in our national productivity.

Lack of access to health care systems means that Hispanics are at a higher risk for certain illnesses than are nonHispanic white populations. Mexican-Americans and Puerto Ricans are twice as likely to have diabetes as nonHispanic whites, while the risk of AIDS for Hispanic adults is almost three times that for nonHispanic white adults. Compassion and economics demand that we do more than provide treatment for illness. We must seek to prevent illness.

We have already discussed the need for more Hispanic health care data within the HHS Department. We do need, Senator, a number of initiatives that I think are contained in the bill that you and Congressman Stokes have introduced that I am cosponsoring.

I would like to also point out something that is very important, and that is there are few Hispanics in the health professions. Hispanics account for only 4 percent of physicians and 2 percent of registered nurses. Mexican-Americans and Puerto Ricans represent only .2 percent and .6 percent, respectively, of medical faculty in

this country. At the national level, less than one percent of over 500 senior executives of the U.S. Department of Health and Human Services are Hispanic. Without a health care system which reflects the community it is supposed to serve, we are unlikely to see the type of culturally sensitive services necessary to provide adequate health care for Hispanics.

The solutions to the serious health care needs of Hispanic Americans won't be easy, but we can't shy away from the task of their development.

Senator, there is one provision that I'm a little bit concerned with in the bill that we are all cosponsoring. I am concerned that the legislation as presently drafted may exclude Hispanic-serving institutions from participating. Specifically, for purposes of distributing funds, the legislation states that minorities may not constitute less than 50 percent of the total number of individuals enrolled.

I would recommend that for purposes of distributing funds and defining minority institutions, the chairman reference Title III of the Higher Education Act, which defines "Hispanic-serving institution" as having an enrollment of which at least 20 percent are Mexican-American, Puerto Rican, Cuban or other Hispanic students. Inclusion of this definition will ensure an equitable distribution of funds within the Disadvantaged Minority Health Improvement Act.

Congressman Bill Gray and I, 2 years ago in a floor discussion, arrived at that 20 percent because basically what was happening was you take the University of New Mexico, which is dramatically trying to increase their number of minorities. We are basically almost a minority State, and you have Hispanics and Native Americans. But we are right now only at 25 percent. And under the legislation, even if it is as high as 25 percent, the University of New Mexico and other institutions like that would not be eligible.

So my suggestion would be that we keep the 20 percent threshold because otherwise a lot of institutions—probably the University of Southern California—that contain large minority Hispanic populations would be excluded.

I am tossing that out for consideration——

The CHAIRMAN. Let me ask you—my own concern is we want to deal with the problem, and we are flexible on the percentages. The issue that is raised is whether, when you get down to the percentages, with limited resources, it is spread so thin you don't really accomplish what you are trying to. Those are basically the arguments. What we obviously want is to reach our objective, and that is why your point is well-taken. we want to work with you about how that can be used most effectively so it is not spread, with the limited resources, so thin that we are not really having much of an impact. That is really the dilemma. But we want to work with you on that. Maybe there are some other ways that that can be developed so that with scarce resources we could achieve our common objectives. I am completely flexible on that, but that is the concern that we have.

In terms of Title III, what has been the practice experience with that?

Mr. RICHARDSON. Well, 2 years ago we brought in the 20 percent figure, and for the first time some institutions with high numbers of Hispanics are starting to share in it. In the past, they weren't participating that actively.

I think the 20 percent is a good one. Now, I understand under limited resources what you are trying to do. Regrettably, Senator—I recall in the floor debate somebody asked me how many Hispanic institutions, for instance, are medical schools, and really, there are none—there is one in Puerto Rico that is not accredited. So that meant that in this specific bucket of funds for Hispanic medical schools—I think this was three years ago—no Hispanic institution was eligible.

I understand what the goals of the legislation are. I just think——

The CHAIRMAN. It would help if the Caucus could review that particular provision and give us the up side and the down side. We would be glad to work with you, if the Caucus could provide that for us.

Mr. RICHARDSON. We'll do that.

The CHAIRMAN. And maybe Congressman Stokes, you could help us with regard to the other minorities, whatever you are able to do, so we have a pretty good idea.

Mr. STOKES. Surely.

The CHAIRMAN. And then we can make whatever judgment—OK.

Mr. STOKES. I am sure we can make the proper adjustments there.

The CHAIRMAN. OK.

Well, I have just a brief question for both of you. how much attention has Minority health received over the period of recent years; what has happened generally? Has it been deteriorating? Has it gotten the needed attention? Have cutbacks in social and public health programs been felt, do you feel, disproportionately in that community?

Mr. STOKES. I might try to answer your question first, Senator. I'd have to say not a great deal of emphasis has been placed on this precise problem. For instance, when Secretary Heckler came out with her report in 1985, the first initiative that she proposed and introduced was that of setting up the Office of Minority Health. That office today, in the last fiscal year, was only funded at a rate of $3 million and about 11 staff positions.

I was able on the current bill now coming between the House and Senate, which will be in conference, to add $1.5 million to that. This means that in the four or five years since 1985, we have only been able to increase that program by $1.5 million. That is not indicative to me of a serious intention to really do something about this exacerbated problem and high differential and disparity between white and black health.

There have been some other programs which we have initiated through the appropriation process, some dealing with biomedical research and the AIDS problem, things of this sort. But in each case, the amount of money appropriated and the resources applied have really been minimal, which means to me that the Federal Government has not yet taken seriously this very high disparity between black and white health care.

I think the problem is even more exacerbated by something that Congressman Richardson said just a few moments ago. In 11 years, in the year 2000, we move into the next century. We were told recently by Workforce 2000, the most authentic and authoritative source recently printed, that in the year 2000 one-third of the new entrants into the work force will be minorities; by the year 2020, two-thirds of the work force in American will be minorities—which means that this Nation, while we see the white population decreasing, the minority population increasing, the Nation will become increasingly dependent upon minorities in the next century.

Obviously, if those minorities are to be able to provide the highly technological work force that this Nation would need to keep it competitive in the world, we will obviously need health Americans, and particularly health minorities, in this next century.

So it seems that this legislation is at the point of something where its time has come, and I think we need to move forward with this legislation to really show that we are serious about this high disparity between minority and white health care in America.

The CHAIRMAN. Congressman Richardson?

Mr. RICHARDSON. I would only echo what Congressman Stokes has said, and I would only add that regarding the recent request for flexibility when they deal with, I think, your proposal and Congressman Stokes' proposal to concentrate a lot of the minority health divisions within a focused area in the Department—when they sometimes say, "Give us flexibility," they basically dilute the effort.

I think it is very clear from the statistics in terms of minority health professionals—I don't know how many minorities Secretary Sullivan has for staff. I notice that he is a perfect example. But nonetheless, I am concerned—I don't know if there are any Hispanics over there. I don't know how many other minorities are on his high-level staff. I think that is something that is of concern.

Again, the statistics in terms of assistance to Hispanics and other minority graduates of medical schools. I think what your bill does and Congressman Stokes 'bill does is it is the first concentrated effort at dealing with the issue of education of more minority health professionals, sensitizing and synthesizing the bureaucracy to deal with minority health problems, dealing also with some comprehensive programs at the grassroots, community-based problems, AIDS babies, you are talking about AIDS resource centers, drug and alcohol treatment centers, availability of prenatal and postnatal care.

What you are doing, I think, for the first time is focusing on the great disparity that exists between minority and white health care, and this is why I think this is an historic situation, especially since now you are backing this with such a concentrated effort.

I know Lou Stokes and Mickey Leland, who is not here, and myself, but mainly them over the years, have been frustrated, especially during the Reagan Administration, by the lack of any kind of sensitivity to these problems—the veto threats and Justice Department questions about quotas and set-asides. Well, I think it has reached the point where we've got to deal with that, and we've got to be human and compassionate, and maybe we have a breakthrough now with your support.

The CHAIRMAN. Let me ask both of you about attracting physicians to minority communities. I think Dr. Sullivan pointed out that reimbursement obviously is a key element. I wish him good luck in trying to deal with that particular issue—and obviously, there are many other features involved in attracting minorities.

Do either of you have any other recommendations or suggestions about how we might get the additional personnel in underserved areas, which in many areas are minority communities?

Mr. STOKES. It might be necessary, Senator, to have some type of program very similar to that which is in existence now where, under the scholarship program, in exchange for the scholarship that you must serve three or four years in an underserved, disadvantaged area. It well might be that some provision of that sort might have to be the inducement to enable these students to actually practice where they are most needed.

Right now, you are relegated in the center city particularly, where you have high indigence and high need for health care, with a shortage of doctors, although there may be an overage of doctors in other parts of the country. So some type of incentive program must be incorporated.

Mr. RICHARDSON. Senator, I would only add this statistic that was done of 1988 medical school graduates—13.6 percent of medical school graduates stated that they planned to practice in medically underserved areas. These are nonminority. When the same question was asked of black and Hispanic medical school graduates, 48.9 percent indicated that they planned to serve in medically underserved areas. The commitment is there; the key is increasing the number of these health professionals. And the problem is, as Congressman Stokes said, financing, it is scholarships. You had 47 percent of those minorities leaving medical school in 1982—47 percent said that the reason that they left was financial difficulties. Again, we have also talked about how we specifically can help serve minority medical institutions, and I think that 50 or 20 is a way to address it. But I would think that this is the key, that we have to start out at the grassroots, at the early education level. And this bill addresses that.

The CHAIRMAN. I think the medical schools ought to be doing more. You know, they get two qualified applicants for every slot. And when you figure that American taxpayers are paying about 60 percent of the costs of medical education—this isn't law school, this is medical education, through the support for basic research programs—middle-income people, the working people, have some interest in this; they have got some real interest.

But if you get two qualified applicants for every slot, the average taxpayer, he would say, if you can get someone who is going to be just as good in terms of quality, and that individual would agree to go to medical school, all things considered, and would be willing to go out and serve in an underserved area—why aren't the medical schools demonstrating some flexibility as well?

I really think they have a very, very important responsibility. What I always hear from the deans is, "Our problem is not to try to resolve the problems in terms of underserved areas; our problem is trying to educate the best." Well, we are all in this together, we are all in this together. We have gone beyond the period where

people can say, "Look, I've just got this concern; I can't worry about somebody else." We are all in this together. And it just seems to me that got some additional responsibility as well.

Mr. STOKES. I might just say, Senator, I think you have touched on something that is very, very important in this area. When you look at the number of black doctors and dentists, more than 50 percent of them have been educated at two institutions in America—Howard Medical School and Meharry Medical School. It has just been in recent years since the advent of Morehouse Medical School that they have made a contribution and of course, now Drew, which are the only four predominantly black medical schools in this country—which is quite an indictment of the majority medical schools in this country.

We also know that since the *Bakke* decision that the number of blacks and other minorities in medical schools has been decreasing rather than increasing. So there is a very real problem there that ought to be addressed through the majority institutions.

The CHAIRMAN. I am delighted to have the chance to have both of you testify, and I hope, Congressman Stokes, that you and I and Congressman Richardson can work very closely in coordination with the Administration. I think we all want to work it out, but I think you reminded us, Congressman Richardson, that when this thing gets spread out over the landscape, it loses the texture, the focus and the identity which we need.

We are serious about trying to work this out, but we do want some accountability in it, and we do want some degree of recognition and priority. That is what this legislation is about.

We want to thank both of you very much for coming over.

Mr. STOKES. Thank you, Senator.

Mr. RICHARDSON. Thank you, Senator.

[Prepared statement of Mr. Richardson follows:]

PREPARED STATEMENT OF HON. BILL RICHARDSON

MR. CHAIRMAN, I APPRECIATE THE OPPORTUNITY TO TESTIFY IN SUPPORT OF THE DISADVANTAGED MINORITY HEALTH IMPROVEMENT ACT OF 1989. I COMMEND YOU FOR YOUR EFFORTS TO IMPROVE THE HEALTH STATUS OF MINORITIES.

HISPANICS HAVE A LONG AND RICH HISTORY OF PARTICIPATION AND CONTRIBUTION TO THE AMERICAN EXPERIMENT. A COMMUNITY OF DIVERSE BACKGROUND, PRIDE, AND ACCOMPLISHMENTS. HISPANIC AMERICANS HAVE BEEN DENIED THE FULL BENEFIT OF THEIR CONTRIBUTIONS TO OUR COUNTRY FOR TOO LONG. POVERTY AND A CONTINUING LACK OF ACCESS TO BASIC HUMAN RESOURCES REMAIN A PERSISTENT FACT OF LIFE FOR MILLIONS OF HISPANICS.

SINCE THE LAST CENSUS. THE HISPANIC POPULATION HAS EXPERIENCED A PHENOMENAL GROWTH. 19.4 MILLION HISPANICS CURRENTLY RESIDE IN THE U.S. MAINLAND WITH ANOTHER 3 MILLION RESIDING IN PUERTO RICO. IN ALL. OVER 22 MILLION PEOPLE WHO REFLECT A RICH MOSAIC OF CULTURE. RACE. AND ETHNICITY. MOREOVER. OVER THE NEXT CENTURY. THIS POPULATION IS PROJECTED TO GROW BY OVER 39 MILLION PERSONS WHILE THE NON-HISPANIC WHITE POPULATION IS PROJECTED TO DECREASE BY 16 MILLION PERSONS. THESE SIGNIFICANT DEMOGRAPHIC TRENDS FORCIBLY ARGUE THAT WE MUST DEAL WITH THE BARRIERS TO THE HISPANIC COMMUNITY'S DEVELOPMENT TO ENSURE OUR NATION'S FUTURE PROSPERITY.

ONE OF THE MOST SIGNIFICANT BARRIERS IS THE PERVASIVE LACK OF ACCESS TO HEALTH CARE SERVICES. ONE IN FOUR HISPANICS (21.7%) HAS NO FORM OF HEALTH INSURANCE -- A RATE THAT IS ALMOST THREE

TIMES THAT OF NON-HISPANIC WHITES (7.7%). NOT SURPRISINGLY, THE LACK OF HEALTH INSURANCE MEANS THAT HISPANICS ARE SIGNIFICANTLY RESTRICTED IN THEIR ACCESS TO OUR NATION'S HEALTH CARE SYSTEM. ONE IN THREE HISPANICS (30.1%) HAS NO REGULAR SOURCE OF HEALTH CARE, A RATE THAT IS ALMOST TWICE THAT OF NON-HISPANIC WHITES (16.3%). THE RESULT IS DELAYED HEALTH CARE, PROLONGED ILLNESS, AND A REAL LOSS IN OUR NATIONAL PRODUCTIVITY.

LACK OF ACCESS TO HEALTH CARE SYSTEMS MEANS THAT HISPANICS ARE AT A HIGHER RISK FOR CERTAIN ILLNESSES THAN ARE NON-HISPANIC WHITE POPULATIONS. MEXICAN-AMERICANS AND PUERTO RICANS ARE TWICE AS LIKELY TO HAVE DIABETES AS NON-HISPANIC WHITES WHILE THE RISK OF AIDS FOR HISPANICS ADULTS IS ALMOST THREE TIMES (2.7) THAT FOR NON-HISPANIC WHITE ADULTS. COMPASSION AND ECONOMICS DEMANDS THAT WE DO MORE THAN PROVIDE TREATMENT FOR ILLNESS -- WE MUST SEEK TO PREVENT ILLNESS.

OUR CURRENT HEALTH EDUCATION AND PREVENTION PROGRAMS SIMPLY DO NOT RECOGNIZE THE DIFFERENT CULTURAL, LINGUISTIC, AND EDUCATIONAL NEEDS OF THE NATION'S POPULATION. ONE IN FIVE HISPANICS CANNOT READ OR WRITE ENGLISH AND SPANISH IS SPOKEN IN THE HOME BY OVER 70 PERCENT OF HISPANICS. HEALTH EDUCATION AND PREVENTION MUST TAKE THESE CHARACTERISTICS INTO ACCOUNT IF THEY ARE TO BE EFFECTIVE IN REACHING HISPANICS.

TRAGICALLY, FEW OF THE PUBLIC HEALTH SERVICE'S 1990 HEALTH OBJECTIVES FOR THE NATION TAKE HISPANIC POPULATIONS INTO CONSIDERATION, CASTING A PALL ON THE DEVELOPMENT OF PHS'S HEALTH OBJECTIVES FOR THE YEAR 2000. FURTHERMORE, OUR NATION'S HEALTH INFORMATION SYSTEMS DO NOT COLLECT, IN AN ONGOING MANNER, BASIC DATA WHICH WOULD SUPPORT EFFECTIVE HEALTH EDUCATION PROGRAMS.

ADDITIONALLY, THERE ARE FEW HISPANICS IN THE HEALTH PROFESSIONS. HISPANICS ACCOUNT FOR ONLY 4 PERCENT OF PHYSICIANS AND 2 PERCENT OF REGISTERED NURSES. MEXICAN AMERICANS AND PUERTO RICANS REPRESENT ONLY 0.2 PERCENT AND 0.6 PERCENT RESPECTIVELY OF MEDICAL FACULTY IN THIS COUNTRY. AT THE NATIONAL LEVEL, LESS THAN ONE PERCENT OF OVER 500 SENIOR EXECUTIVES IN THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES ARE HISPANIC. WITHOUT A HEALTH CARE SYSTEM WHICH REFLECTS THE COMMUNITY IT IS SUPPOSED TO SERVE, WE ARE UNLIKELY TO SEE THE TYPE OF CULTURALLY SENSITIVE SERVICES NECESSARY TO PROVIDE ADEQUATE HEALTH CARE FOR HISPANICS.

THE SOLUTIONS TO THE SERIOUS HEALTH CARE NEEDS OF HISPANIC AMERICANS WILL NOT BE EASY, BUT WE CANNOT SHY AWAY FROM THE TASK OF THEIR DEVELOPMENT. WE CAN NO LONGER BE SATISFIED WITH BAND-AID SOLUTIONS AND THEN SLAP OURSELVES ON THE BACK FOR OUR COMMITMENT AND A JOB WELL DONE. A BUSINESS AS USUAL RESPONSE IS A DISSERVICE NOT ONLY TO THE GROWING HISPANIC COMMUNITY BUT TO THE NATION AS A WHOLE.

I CONGRATULATE SENATOR KENNEDY AND CONGRESSMAN STOKES FOR THEIR DEVELOPMENT OF THE DISADVANTAGED MINORITY HEALTH IMPROVEMENT ACT WHICH WILL ADDRESS THE NEED FOR INCREASED NUMBERS OF MINORITY HEALTH PROFESSIONALS, AND COORDINATE NEW PROGRAMS OF HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS THROUGH THE OFFICE OF MINORITY HEALTH. I AM CONCERNED HOWEVER, THAT THE LEGISLATION AS PRESENTLY DRAFTED MAY EXCLUDE HISPANIC-SERVING INSTITUTIONS FROM PARTICIPATING. SPECIFICALLY, FOR PURPOSES OF DISTRIBUTING FUNDS, THE LEGISLATION STATES THAT MINORITIES MAY NOT CONSTITUTE LESS THAN 50 PERCENT OF THE TOTAL NUMBER OF INDIVIDUALS ENROLLED. I WOULD RECOMMEND THAT FOR PURPOSES OF

DISTRIBUTING FUNDS AND DEFINING MINORITY INSTITUTIONS. THE CHAIRMAN REFERENCE TITLE III OF THE HIGHER EDUCATION ACT WHICH DEFINES HISPANIC SERVING INSTITUTIONS AS HAVING AN ENROLLMENT OF WHICH AT LEAST 20 PERCENT ARE MEXICAN AMERICAN, PUERTO RICAN, CUBAN OR OTHER HISPANIC STUDENTS. INCLUSION OF THIS DEFINITION WILL ENSURE AN EQUITABLE DISTRIBUTION OF FUNDS WITHIN THE DISADVANTAGED MINORITY HEALTH IMPROVEMENT ACT.

I AM PLEASED THIS SENATE EFFORT WILL PARALLEL AN UNPRECEDENTED COOPERATIVE, LEGISLATIVE EFFORT CURRENTLY BEING UNDERTAKEN IN THE HOUSE BY BLACK AND HISPANIC CONGRESSMEN AND OTHERS ACTIVE IN THE FIGHT TO PROVIDE HEALTH CARE TO BLACK AND HISPANIC AMERICANS. SPEARHEADED BY CONGRESSMAN MICKEY LELAND, THE AMERICANS HEALTH PARITY ACT WILL ADDRESS MANY OF THE HEALTH ISSUES I HAVE DISCUSSED TODAY. IN BRIEF, THE AMERICANS HEALTH PARITY ACT SEEKS AMONG OTHER THINGS TO:

- COLLECT HISPANIC HEALTH DATA AS AN ONGOING EFFORT OF OUR NATIONAL HEALTH DATA COLLECTIONS SYSTEMS;
- REQUIRE SPECIFIC OBJECTIVES FOR BLACK AND HISPANIC COMMUNITIES UNDER THE YEAR 2000 HEALTH OBJECTIVES;
- INCREASE THE AVAILABILITY OF PRENATAL AND POSTNATAL HEALTH CARE TO LOW INCOME INFANTS AND MOTHERS BY EXPANSION OF MEDICAID;
- PROVIDE COMPREHENSIVE DRUG AND ALCOHOL TREATMENT PROGRAMS THROUGH CONSORTIUMS OF COMMUNITY HOSPITALS, HEALTH CENTERS, AND COMMUNITY BASED ORGANIZATIONS:
- AND ESTABLISH PEDIATRIC AIDS RESOURCE CENTERS THROUGH CONSORTIUMS OF COMMUINTY HOSPITALS, HUMAN SERVICE AGENCIES, AND COMMUNITY BASED ORGANIZATIONS,

AS WELL AS THE HEALTH PROFESSION AND OFFICE OF MINORITY HEALTH OBJECTIVES OF THE DISADVANTAGED MINORITY HEALTH IMPROVEMENT ACT ANNOUNCED TODAY.

THE PRIDE I FEEL IN THE UNPRECEDENTED LEVEL OF COOPERATION BETWEEN COLLEAGUES WHO REPRESENT SIGNIFICANT BLACK AND HISPANIC CONSTITUENCIES IS FURTHERED BY THE LEVEL OF ASSISTANCE WE HAVE RECEIVED FROM BLACK AND HISPANIC NATIONAL ORGANIZATIONS WORKING IN FULL COOPERATION. THIS LEVEL OF COOPERATION IS ONE OF THE LEGACIES OF CONGRESSMAN MICKEY LELAND. IT WAS HIS HOPE THAT THE AMERICANS HEALTH PARITY ACT WOULD NOT ONLY MAKE SIGNIFICANT CONTRIBUTIONS TO THE HEALTH OF BLACK AND HISPANIC COMMUNITIES BUT WOULD INSTITUTE NEW AND HISTORIC RELATIONSHIPS BETWEEN THE ELECTED REPRESENTATIVES OF BLACK AND HISPANIC CONSTITUENCIES AS WELL AS COOPERATION BETWEEN ORGANIZATIONS REPRESENTING BLACK AND HISPANIC COMMUNITIES.

I SHARE THE URGENCY MICKEY ATTACHED TO THE AMERICANS HEALTH PARITY ACT. IF WE ARE TO BE SUCCESSFUL IN ADDRESSING THE HEALTH NEEDS OF GROWING BLACK AND HISPANIC COMMUNITIES. THEN TIME IS OF THE ESSENCE. THE ECONOMIC REALITIES ARE PLAIN. IF WE IGNORE THE CHANCE TO DEAL WITH THE CURRENT HEALTH CARE NEEDS OF BLACK AND HISPANIC AMERICANS, THOSE NEEDS WILL ONLY BECOME MORE PREVALENT AND EXPENSIVE TO DEAL WITH IN THE FUTURE. DENIAL OF HEALTH CARE TO SUCH A SIGNIFICANT POPULATION IS UNACCEPTABLE. MOREOVER, IF THIS COUNTRY IS TO ENJOY FUTURE PROSPERITY, THEN THE HEALTH CARE NEEDS OF BLACK AND HISPANIC AMERICANS MUST BECOME A PRIORITY TODAY.

The CHAIRMAN. For our third panel, we have Dr. Herbert Nickens, Vice President, Disease Prevention and Health Promotion, Association of American Medical Colleges; and Dr. Jane Delgado, President and CEO, National Coalition of Hispanic Health and Human Services Organization.

Dr. Nickens, we'll start with you.

STATEMENTS OF DR. HERBERT NICKENS, VICE PRESIDENT, DISEASE PREVENTION AND HEALTH PROMOTION, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, WASHINGTON, DC, AND DR. JANE L. DELGADO, PRESIDENT AND CEO, NATIONAL COALITION OF HISPANIC HEALTH AND HUMAN SERVICES ORGANIZATION, WASHINGTON, DC

Dr. NICKENS. Mr. Chairman, I'd like to thank you for the opportunity to testify before you today on the Disadvantaged Minority Health Improvements Act of 1989 and on the health problems of minorities in the United States in general.

I would also like to make clear that my testimony does not reflect or represent official positions of the Association of American Medical Colleges; however, that organization's past record as well as its recent creation of a Division of Minority Health, Disease Prevention and Health Promotion, make me confident that there is little that I might say that would not be congruent with the Association's views.

In the time allotted to me today, I'd like to touch on four issues: first, the multiracial/multiethnic nature of American society today; second, the differentials in health status among racial/ethnic minority groups; third, recommendations for strategies for solutions; and fourth, the Federal Government role in the solution.

First, as we approach the 21st century, American cannot continue to view herself as she has historically as being populated overwhelmingly by whites and by nonwhites, the latter of which nearly all are black.

As you can see from the slide, there are four major minority groups in the United States: blacks, Hispanics, Native Americans and Asian/Pacific Islanders. These groups currently comprise about one out of five Americans. However, the growth rate of all four populations is much more rapid than that of the majority white population. Whites will continue to be the majority in the United States for the foreseeable future.

However, in States such as California, whites are likely to become the minority early in the next century. It is also important to understand that not only are these four major minority groups different from one another; there are dramatic differences within each minority group. For example, newly-arrived refugees and immigrants from Vietnam, Laos and Kampuchea may have more in common with newly-arrived Central Americans refugees and immigrants than either has with Japanese Americans or with Cuban Americans.

This diversity in culture, language, median age, fertility rates, education and income, all have important implications for health program planning and design. All too often these factors are taken into account inadequately or not at all.

Second, the health status of minority groups also differ dramatically one from the other as well as from the white population. This is true despite the fact that we commonly speak in unitary terms of "minority health".

Now, what this slide shows you is the ratio of death rates for blacks compared to whites throughout the life course. If blacks and whites had the same death rates throughout the life span, what you would see across there is a straight line—I don't have a pointer, but I will use my finger—you would see a straight line. What you see is something quite different.

This U-shaped curve—and what we have here are ratios of mortality rates starting off at age 15, there on the left, and going out to about age 85—this U-shaped curve shows that the ratios of death rates for blacks and whites never equal one until you get out to about age 80, out here, and are extremely adverse for blacks as you approach middle-age. And what you see here is in the middle, the ratio of death rates, blacks compared to whites, is about two-to-one, or more than two-to-one, in the normally healthy years of the 30s and 40s.

All this space inside the U are what were termed by the task force report as "excess deaths"—those are deaths which would not have occurred if blacks had the same death rates as whites.

The next four slides will show you the excess death rates for the four major minority populations compared to the white population, as calculated in the 1985 report of the Secretary's Task Force on Black and Minority Health.

The first slide is for the black population, and you can see over here on the right, the excess death percentage is 42 percent. That means of all the blacks who die every year, prior to age 70, 42 percent would not die if blacks had the same death rates as the white population. And that is that 59,000, or 60,000 sometimes it is rounded off to, excess death figure which you hear quoted so many different times. Those are populations from the 1980 Census data on the left.

In fact in this country, black death rates are 50 percent higher than those for whites, and blacks have the worst overall health status of any minority group in the country. In fact, death rates, as you have heard before, are increasing over the last couple of years, while those for whites have been decreasing.

For Native Americans, you can see again a pretty awful 22 percent of deaths are excess deaths. It is a much smaller number because Native Americans are a much smaller population. But the percentage of deaths that are excess is 22 percent—different from blacks, but again, pretty terrible.

Hispanic Americans, the excess death rate here is very roughly—and I emphasize very roughly—10 percent. That is based on regional data, and as you have heard from Congressman Richardson and others, we don't have national data for Hispanics, and these are calculated on local data that we do have. I think it is also important to point out that death rates within the Hispanic population vary greatly one from the other. It is our belief that Puerto Rican populations have much worse health status, more like black populations, than those of Cuban Americans, for example.

Finally, Asian Americans. You can see a minus excess death rate, which means Asians overall have a better health status than white populations. Again, though, we have to wonder what is going to happen to the tremendous increase we have seen in Southeast Asian refugee populations who are coming in, who are extremely poor, and we don't know what their health status is going to be yet based on mortality rates because the populations are so young, they haven't begun to die yet in large numbers. We will know that in the future. But most of us are very worried about this population. Poverty rates for those populations are 30 to 40 percent. So our traditional Asian populations may be doing well, but we have other Asian populations to worry about.

It is important that resource allocations be done on the basis of health status. Health programs should not be seen as another pork barrel. Access to this funding stream should be given on the basis of death and suffering, not constituency politics.

The third point. Strategies to improve minority health must include at least three components. The first, increased attention to health promotion and disease prevention programs which are culturally sensitive and culturally appropriate to the target population. Meryl Streep is not appropriate to do AIDS education in Harlem.

The second point—access to health care. That just means what it says. We need to have people who have insurance and also health care facilities that are set up to receive those people at times and in ways that makes them enabled to access that system.

Third—training of researchers and health professionals who are members of a variety of ethnic groups.

Health promotion and disease prevention is an essential component of any minority health strategy because the diseases which kill all of us in American now depend heavily on our behavior and our lifestyle. This is true whether you are talking about diseases that develop over a long period of time, such as cardiovascular disease and cancer, or an infectious disease such as AIDS. In all of these cases, our behavior is an essential component of either prevention or acquisition of disease.

Fourth, the Federal Government has a critical role to play in the improvement of minority health status. More money needs to be allocated for this purpose, and those funding levels need to be sustained—and this is the tricky part—sustained over a 10- to 20-year time period.

In addition, there are two other problems that need to be recognized. First, the agencies that are important to achieve optimal progress in minority health are under diverse lines of authority and control, making them difficult to organize into a sustained effort. Specifically here, I am referring to the Department of Education, and within the Department of Health and Human Services, the Family Support Administration, Health Care Financing Administration, Office of Human Development Services, and the Public Health Service.

The CHAIRMAN. Let me just interrupt there. You were here when Dr. Sullivan spoke about the concerns he has for the way this legislation is dealing with the organization of the programs.

I don't know whether you have some insights; maybe you have some ideas, concerning the organization of programs in DHHS relating to minority health.

Dr. NICKENS. Toward the end of my statement, I actually make a recommendation that at least will, hopefully, suggest a direction.

Part of the problem with this diversity of programs is that minority health is everyone's responsibility and therefore it is no one's responsibility.

The second point is that even within a more unified organizational entity such as the United States Public Health Service, there are substantial problems with turf and with fractioning of responsibility. The result is that resources are often used in an inefficient manner, based on the parochial perspectives of an individual operating unit. This makes it very difficult to carry out an overall strategy.

I have three recommendations that might be helpful in this regard. Number one, create select committees on minority health in the House and Senate so that there is a Congressional body dedicated to tracking these issues; second, urge the Secretary of Health and Human Services to create an ongoing task force on black and minority health, whose mission would be to rationally allocate resources and plan programs throughout HHS, designed to close the minority/majority health status gap.

There is no substitute for ongoing Secretarial interest in this issue. We can't always assume that we are going to have a Secretary Sullivan who is committed to this issue, and yet Secretarial interest is essential. So somehow, we have to find a way to maintain that.

As a part of the ongoing task force described above, a component to achieve interdepartmental coordination with the Education Department is essential.

The third recommendation is that to the extent that the aforementioned mechanisms are not implemented, the budget of the Office of Minority Health will need to be increased to a level where operating alone, it can make direct substantial national impact. Under this scenario, the Office's budget requirements could reach several times that envisioned in this bill.

In closing, I'd like to say that it is embarrassing and morally unacceptable that we have Third World health statistics within hailing distance of this chamber. Even with an all-out effort, closing the minority/majority health gap may take decades, but as a Nation, we don't know because we have never really tried.

Thank you, and I'd be pleased to answer any questions.

[Prepared statement of Dr. Nickens follows:]

PREPARED STATEMENT OF HERBERT NICKENS

Mister Chairman I would like to thank you for the opportunity to testify before you today on the "Disadvantaged Minority Health Improvements Act of 1989" and on the health problems of minorities in the United States in general. I would also like to make clear that my testimony does not represent official positions of the Association of American Medical Colleges. However, that organization's past record as well as its recent creation of a Division of Minority Health, Disease Prevention/Health Promotion make me confident that there is little that I may say which would not be congruent with the Association's views.

In the time allotted to me today I would like to touch on 4 issues:

1. The multiracial/multiethnic nature of American society today.
2. The differentials in health status among racial/ethnic minority groups
3. Recommendations for strategies for solutions
4. The Federal Government role in the solution

1. As we approach the 21st century America cannot continue to view herself, as she has historically, as being populated overwhelmingly by Whites and by non-Whites the latter of which nearly all are Black.

SLIDE-1

As you can see from the slide there are four major minority groups in the

United States: Blacks, Hispanics, Native Americans, and Asian/Pacific Islanders. These groups currently comprise about 1 out of 5 Americans. However, the growth rate of all four populations is much more rapid than that of the majority White population. Whites will continue to be the majority in the U.S. for the foreseeable future. However, in states such as California, Whites are likely to become the minority early in the next century. It is also important to understand that not only are these four major minority groups different from one another, there are dramatic differences within each minority group. For example, newly-arrived refugees and immigrants from Vietnam, Laos and Kampuchea may have more in common with newly-arrived Central American refugees and immigrants than either has with Japanese Americans or Cuban Americans. This diversity--- in culture, language, median age, fertility rates, education and income--- all have important implications for health program planning and design. All too often these factors are taken into account inadequately or not at all.

2. The health status of minority groups also differ dramatically one from the other as well as from that of the White population. This is true despite the fact that we commonly speak in unitary terms of "minority health."

SLIDE-2

The next slide shows a ratio of death rates for Blacks compared to Whites throughout the life course. If Blacks and Whites had the same death rates throughout the lifespan what you would see is a straight line. What you see is something quite different. This U-shaped curve shows that the ratios of death rates for Blacks and Whites never equal one until you reach

age eighty and are extremely adverse for Blacks as you approach middle age. This space within the "U" is what may be termed "excess deaths", deaths which would not have occurred if Blacks had the same death rates as Whites. The next four slides show you excess death rates for the four major minority populations compared to the White population as calculated in the 1985 Report of the Secretary's Task Force on Black and Minority Health.

SLIDE- 3-6

What these data show you is that Blacks overall have the worst health status of any minority group. In fact, overall Blacks death rates are 50% higher than those for Whites, and are increasing. It is important to say once again that these are averages across minority groups. For example, Puerto Ricans have substantially worse health status than Cuban Americans or Mexican Americans. It is also important that resource allocations be done on the basis of health status. Health programs should not be seen as another pork barrel. Access to this funding stream should be given on the basis of death and suffering, not constituency politics.

3. Strategies to improve minority health must include at least 3 components: 1) increased attention to health promotion and disease prevention programs which are culturally sensitive and culturally appropriate, 2) access to health care, and 3) training of researchers and health professionals who are members of a variety of ethnic groups. Health promotion/disease prevention is an essential component of any minority health strategy because the diseases which kill us in America now depend heavily on our

behavior and lifestyle; this is true whether you are talking about diseases that develop over a long period of time such as cardiovascular disease and cancer or an infectious disease such as AIDS--in all of these cases our behavior is an essential component of either prevention or acquisition of disease.

4. The Federal Government has a critical role to play in the improvement of minority health status. More money needs to be allocated for this purpose and those funding levels need to be sustained over a 10-20 year time period. In addition there are two other problems that need to be recognized:

1. The agencies that are important to achieve optimal progress in minority health are under diverse lines of authority and control, making them difficult to organize into a sustained effort. Specifically here I am referring to the Department of Education, and-- within the Department of Health and Human Services-- the Family Support Administration, Health Care Financing Administration, Office of Human Development Services, and the Public Health Service. Minority health is everyone's responsibility and, therefore, it is no one's responsibility.

2. Even within a more unified organizational entity such as the U.S. Public Health Service there are substantial problems with "turf" and fracturing of responsibility. The result is that resources are often used in a inefficient manner, based on the parochial perspective of

an individual operating unit. This makes it very difficult to carry out an overall strategy.

Recommendations:

1. Create Select Committees on Minority Health in the House and Senate so that there is a Congressional body dedicated to tracking these issues.

2. Urge the Secretary of Health and Human Services to create an ongoing Task Force on Black and Minority Health whose mission would be to rationally allocate resources and plan programs throughout HHS designed to close the minority-majority health status gap. There is no substitute for ongoing Secretarial interest in this issue. As a part of the ongoing Task Force described above, a component to achieve inter-Departmental coordination with the Education Department is essential.

3. To the extent that the aforementioned mechanisms are not implemented, the budget of the Office of Minority Health will need to be increased to a level where operating alone it can make direct, substantial national impact. Under this scenario the Office's budget requirements could reach $ 100 million or more.

In closing I'd like to say that it is embarrassing and morally unacceptable that we have third world health statistics within hailing distance of this chamber. Even with an all-out effort, closing the minority-majority health gap may take decades. But as a nation we don't know, because we've never really tried.

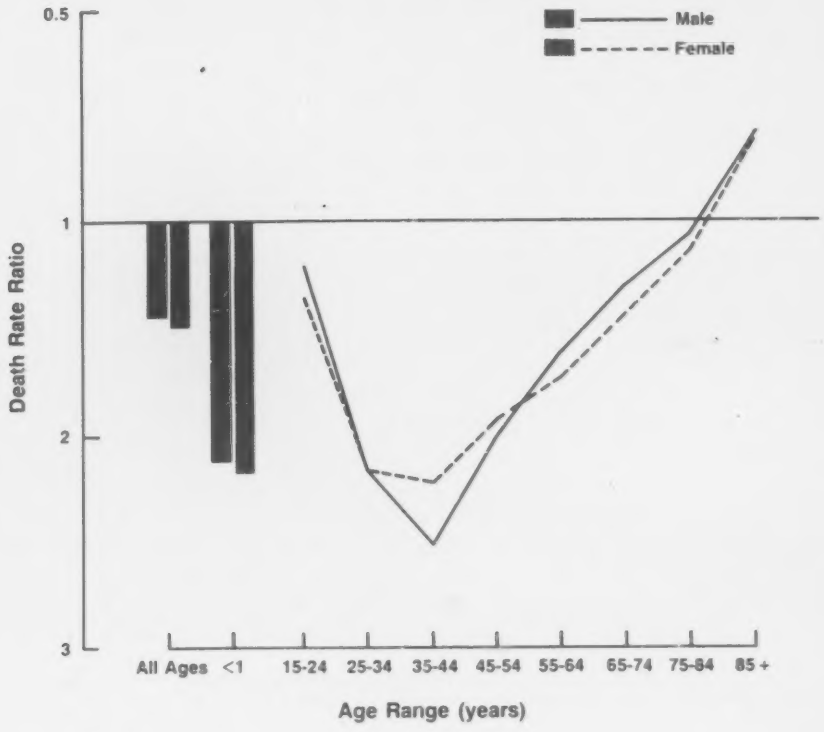
Slide 1 Major Minority Groups in the United States

- BLACKS
- NATIVE AMERICANS
- HISPANICS
- ASIAN/PACIFIC ISLANDERS

Slide 2

Ratio of Black to White Death Rates for All Causes

Deaths per 100,000 U.S. Residents, by Age and Gender: 1983



Slides 3-6 Net excess deaths by minority group

	BLACKS	HISPANICS	NATIVE AMERICANS	ASIANS
U.S. Population[a] (% of total)	26.1 (11.5%)	14.5 (6.5%)	1.5 (<1%)	3.7 (1.6%)
Excess Deaths[c]	58,942	≈ 7,000[b]	1,042	-819
Excess/Total Deaths(%)[c]	42%	≈ 10%[b]	22%	-14%

a) 1980 U.S. Census Population in millions.

b) These are rough estimates made from Texas surname data, and Mexican/Cuban born data. They are provided to give some idea of the order of magnitude of excess deaths in Hispanic populations ≈ = approximately.

c) Excess deaths are calculated as an average of the years 1979-1981. Excess deaths = (the number of deaths actually observed prior to age 70) minus (the number of deaths which would be predicted when age and sex specific death rates of the U.S. white population are applied to the minority population)

Source: Report of the Secretary's Task Force on Black and Minority Health: Vol. I, Executive Summary, Washington, D.C., U.S. Department of Health and Human Services, August 1985.

The CHAIRMAN. Dr. Delgado?

Dr. DELGADO. I am very glad to be here, and I have written testimony that I would like to submit. I also would like to spend my time just highlighting some of my major concerns, which I presented in my testimony.

The CHAIRMAN. Yes, all the statements will be included in the record in their entirety as if read.

Dr. DELGADO. I want to first thank you for having this hearing and also thank Senator Hatch for his longstanding commitment to the Hispanic community and his curiosity always to find out what our latest statistics are.

One of the interesting things about my statement is that this is a joint statement between COSSMHO and the National Urban League. We work as staff on the Ad Hoc Committee on Black and Hispanic Health and, for the past year and a half, have worked very strongly to try to bring the health agenda of African Americans—which is the term the National Urban League prefers to use—and Hispanic Americans to the forefront. So we were very pleased when this bill first came forward.

Our concern with the current bill is only one, and I think it was touched upon by Congressman Richardson, which is the number of 50 percent. That number leaves out every school in the West, Southwest and Northeast, which is where most Hispanics reside and go to school. So we are very concerned about that number, and I know, Senator, that you said that you would try to work that out.

If we see the current bill as an important first step in trying to improve the health of African Americans and Hispanic Americans, then I have to take this opportunity to tell you what are the next steps which are crucial.

The first one, which kept coming up as good data—and I was very flattered personally to keep hearing reference to the Black Minority Health Task Force Report since that was the report that I worked on as the Secretary's staffperson—and it is interesting to see what excerpts people have selected to use. For example, the number of excess deaths is used a lot. When I did that report, being a Hispanic, I sacrificed my community knowing that those data were not available for Hispanics; so all the data you hear about excess deaths or life expectancy, you won't hear Hispanic because the data were not there and will not be there for at least another two or three years—but to improve the health of the whole, sometimes you have to do difficult things, and that was one of them.

The other thing is data is very difficult in HHS to obtain. Secretary Bowen appointed me to the National Committee on Health and Vital Statistics, and I have to admit that with the Health Care Financing Administration, it is still a struggle to get them to collect data besides white and other, and it will continue to be so without support from the Hill.

So the idea of data becomes very important. And also we were constantly telling people to please isolate the data presented separate for Puerto Rico because of the unique problems of the island. So data becomes one issue.

The second issue is OMH is a very important office; it is a coordinating office. That you empower OMH should not be seen as an in-

stance of relieving the rest of the Department of their responsibility. And I think whatever you do to empower OMH, you have to see how it affects the rest of the Department.

Finally, especially for the Hispanic community, the integral role of community-based organizations. I can tell you that with both the COSSMHO members and the National Urban League members, that those CBOs have been integral in providing services and information to communities which no one else has wanted to serve. Very often, those State and local health entities have not reached out to either one of our communities. So when you think of whom you are funding, please make sure they are the people who are serving the people, and not the people who are making money from the people.

Lastly, several times people asked you about the cost of these activities. I think there is something to be said about the major savings. For example, one of the things we know is in diabetes prevention for Hispanics, it is crucial when Hispanics come in late in the course of the illness, they will come in with a need for amputations and more severe types of treatments. If you catch them early, you can prevent a lot of the health care costs, you can prevent a lot of the loss of time from work. So there is a whole other side to the equation; it is not just the money you may be putting aside now, but the other side—what is the health care savings to the whole health care community.

Those are basically some of the things I wanted to highlight from my statement.

Thank you very much.

[The prepared statement of Dr. Delgado and a letter from the Congressional Hispanic Caucus follows:]

PREPARED STATEMENT OF JANE L. DELGADO

Senator Kennedy, Senator Hatch, and members of the Labor and Human Resources Committee, my testimony today is on behalf of COSSMHO and also on behalf of the National Urban League. I have served as President and Chief Executive Officer of the National Coalition of Hispanic Health and Human Services Organizations (COSSMHO) since 1985.

COSSMHO and the National Urban League have been pleased to provide support and technical assistance to the Ad-Hoc Committee on Black and Hispanic Health formed at the beginning of the 101st Congress. The Ad-Hoc Committee brings together over 15 staff members from the House and Senate, representing individual members as well as key committees and subcommittees concerned with health legislation and appropriations. The formation of this group, along with the participation of COSSMHO and the National Urban League, provides the opportunity to examine not only the commonalities of health problems experienced by two of the nation's largest communities - Hispanic Americans and African Americans - but also to bring the unique characteristics and needs of each group to the table as legislative responses are considered.

One of the accomplishments of the Ad-Hoc Committee is legislation titled the Americans Health Parity Act. The legislation, which will be introduced in the coming weeks, will stand as one of the many legacies of Congressman Mickey Leland. He was a major force in bringing together the Ad-Hoc Committee on Black and Hispanic Health and in shaping the Americans Health Parity Act. He

saw that Hispanic Americans and African Americans were being shut out of the health care system and that only a cooperative agenda would have a chance of reversing this reality. All of us concerned with the health of Hispanic Americans and African Americans should acknowledge the debt we owe to Mr. Leland, a leader whose vision and compassion allowed him to bring diverse interests together for the common good. If we can continue in this cooperative manner, his memory will be well served.

My testimony presents comments on several aspects of the "The Disadvantaged Minority Health Improvement Act of 1989." I will also address priorities beyond the scope of this legislation which should be given very careful consideration. As a context for these remarks, I would like to provide in summary form several observations about the state of health in Hispanic American and African American communities and significant demographic trends.

Health Status and Utilization

As a nation, we have reached a critical stage in the development of our health care delivery system. While the country as a whole has seen its health status improve, there has been a growing disparity between improving the national picture and the erosion of health status for Hispanic Americans and African Americans. From the earliest moments of life to the senior years, Hispanic Americans and African Americans face serious challenges to their health. An examination of leading health indicators among Hispanic Americans and African Americans points to a national crisis in health care. These are just some of the facts:

Hispanic American health means that:

- There is a pervasive lack of national data on the health status of Hispanic Americans; many basic national health status indicators are currently not available for Hispanics, including the number of Hispanic men, women, and children who die in this country every year.
- Hispanics are less likely than any other group to have health insurance.
- One in three Hispanics does not have a regular source of health care.
- A Hispanic mother is more than three times as likely to receive late or no prenatal care as a non-Hispanic mother.
- Mexican Americans and Puerto Ricans are twice as likely to have diabetes than are non-Hispanic whites.
- The cumulative incidence of AIDS for Hispanics is 2.7 times higher than among non-Hispanic whites.
- Only four percent of physicians in the U.S. are Hispanic.

African American health means that:

- An African American child is twice as likely to die within the first year of life as a white child.
- African Americans have experienced a continuing erosion in life expectancy so that today an African American's life expectancy is six years shorter than that of his or her white peer.
- The death rate from heart disease among African Americans is twice that among white Americans.
- The relative risk of AIDS for African American children is eleven times higher than for non-Hispanic white children.
- One in five African Americans does not have a regular source of health care.
- Only three percent of physicians in the U.S. are African Americans.

Finally, it is critical to note that for both African Americans and Hispanic Americans, cocaine use increased by approximately 60% since 1985, while cocaine use for the population as a whole declined.

Communities of Growth

The disparity in health experienced by African American and Hispanic American communities is not a new phenomena. The most comprehensive report was issued by Margaret Heckler, Secretary of the U.S. Department of Health and Human Services, in 1985. That report documented both the extremely limited data on Hispanic Americans and the gaps between the health status of selected racial and ethnic communities and non-Hispanic whites.

The disproportionate burden of morbidity and mortality in these communities is one compelling reason for Congressional action. The demographics of growth underscore that the long-term prospects for America's productivity and national well-being increasingly will rest upon the shoulders of Hispanic Americans and African Americans.

Almost one out of every five persons in this country today is an African American or Hispanic American. The Hispanic American population increased from 14.3 million in 1980 to an estimated 17.5 million in 1985. This 3.2 million numerical gain is equivalent to a five-year growth rate of 22.9 percent, four times the rate of increase experience by the total U.S. population. While Hispanic Americans accounted for 6.3 percent of the U.S. population in 1980, they accounted for 7.3 percent of the population in 1985 and are estimated to represent 8.1 percent of the population in 1988.

The African American population increased from 26.7 million in 1980 to an estimated 28.9 million in 1985. The 2.2 million increase translates to a growth rate of 8.3 percent, one and one-half times the rate for the total population of the United States for the same time span. African Americans accounted for 12.1 percent of the U.S. population in 1985 as opposed to 11.8 percent five years earlier.

The phenomenal growth rates for Hispanic Americans and African Americans are predicted to continue well into the next century. While the non-Hispanic white population is predicted to decrease by 7.5 million people between 1985 and 2080, the African American population is expected to grow by 26.6 million people and the Hispanic American population is predicted to grow by 42.3 million people.

These two groups also are among the most youthful segments of what is considered, on a national basis, an aging population. By the year 2000 it is projected that almost one third of the working age population will be comprised of Hispanic Americans and African Americans.

The Disadvantaged Minority Health Improvement Act of 1989

This legislation is commendable in its attempts to provide legislative authority and expanded budgets for the Office of Minority Health and for its attention to the underrepresentation of Hispanic Americans and African Americans in health professions schools. The proposed legislation also recognizes the unique conditions of health in the Trust Territories of the Pacific Islands - needs that too often are obscured by the great distance from the heart of our nation. While we have no recommendations directed to Title I, which addresses the Office of Minority Health and the various program initiatives, there are several concerns we wish to raise regarding Title II - Disadvantaged Minorities in Health Professions.

Increasing African American and Hispanic American enrollment in health professions schools is a necessary component of a comprehensive approach to

improving the health of Hispanic Americans and African Americans. Data on enrollment trends demonstrate the degree to which the nation has failed to break down financial and other barriers that place health professions beyond the reach of many in these communities.

Between 1978 and 1988, the proportion of African Americans graduating from medical school dropped from 5.5% to 5.1%. In that same time period, the proportion of Mexican American graduates increased only slightly, from 1.1% to 1.5%, while the gain for mainland Puerto Rican graduates was even less significant, increasing from .4% to .5%.

These figures represented a systemic failure of our education system, but there is an equally troubling concern about the impact on access to care. A survey of 1988 medical school graduates revealed that only 13.6% of all graduates stated they were planning to practice in medically underserved areas, compared to 48.9% of African American and Hispanic American medical graduates. With large proportions of Hispanic Americans and African Americans living in poverty - approximately 25% and 33%, respectively, large numbers of both communities are likely to reside in medically underserved areas. Clearly, non-Hispanic white medical graduates have only a minimal interest in working in these areas. The burden of care - present and future - rests with Hispanic American and African American health professionals.

The legislation as drafted provides a variety of financial incentives aimed at increasing the enrollment of Hispanic Americans and African Americans in health professions schools. At present, the legislation states that fifty percent of financial aid authorized must be directed to schools at which "underrepresented minority students constitute not less than fifty percent of total enrollment."

We are concerned that the proposed definition of eligibility for institutional participation (50%) is overly restrictive. The many discussions on this topic held as part of the work of the Ad Hoc Committee on Black and Hispanic Health yielded consensus around a figure of 20% enrollment for overall eligibility. This lower figure (20%) represents, in fact, the approximate proportion of Hispanic Americans and African Americans in the overall U.S. population and provides an appropriate marker for equity and representation in health professions schools.

One consistent standard for eligibility sends a strong, much-needed message: those schools which have displayed commitment to Hispanic American and African American recruitment and education will have new resources at their disposal; those which have not met the threshold will have new incentives to increase enrollment. It is notable, for example, that the 50% threshold removes from half of the funding opportunities every medical school in the heavily Hispanic populated Northeast, West, and Southwest.

Consideration also should be given to providing increased support for those health professionals locating in medically underserved areas at the completion of their education and training. As now drafted, the legislation provides financial incentives for graduates to seek faculty appointments for a period of not less than two years. While underrepresentation of Hispanic Americans and African Americans on faculties is of concern, the need to assure a continuing and growing supply of health professionals in the rapidly increasing African American and Hispanic communities must also be addressed.

Given the reluctance of non-Hispanic white graduates, in the case of medical schools, to relocate to medically-underserved areas the logical response is to recruit from those most likely to serve in those areas - Hispanic Americans and African Americans themselves. Accordingly, we believe the legislation should give to the Secretary authority to use loan repayment plans and other means to assist and encourage such practices. With these changes, the Disadvantaged Minority Health Improvement Act of 1989 will have even greater potential to favorably affect Hispanic American and African American health and remove barriers which have prevented significant increases in Hispanic American and African American enrollment in health professions schools.

Concluding Remarks

The future health of Hispanic Americans and African Americans depends to a great degree on the availability of health care practitioners in these communities - as well as the infrastructures within these communities that provide the foundation for health promotion, disease prevention, and comprehensive care and treatment. The Disadvantged Minority Health Improvement Act of 1989 provides part of the response for building new resources in both of these areas, and we look forward to its passage.

Simultaneously, we must look at broader measures, such as those which drew the concern and legislative leadership of Congressman Leland and Congressman Richardson together. As this committee continues its assessment of ways to improve the health of selected communities, it will be important to keep as priorities five major objectives:

1. Health data collected by the U.S. Department of Health and Human Services should reflect uniform use of Hispanic identifiers, as well as existing racial identifiers. Data collection methodology should reflect oversampling of Hispanic Americans, African Americans, and other populations as necessary to yield meaningful sample sizes.

These measures will assist decision-makers at all levels of government as they assess ways of achieving greater parity in health status and access to the health care system. We have seen improvements in federal data collection in this regard in the last ten years, but legislative action will be required to bring uniformity to such efforts. It is also important to recognize that meeting these higher standards for data will, in some cases, result in higher data collection costs.

2. The new emphasis on the coordinating and program funding role of the Office of Minority Health should not relieve the other agencies within the U.S. Department of Health and Human Services of directing appropriate levels of funding to African American, Hispanic American, and other populations.

While the higher levels of appropriations authorized for OMH will support much-needed service demonstration, research, and education, the new funding will still constitute a minuscule proportion of DHHS expenditures. This committee can continue to play a key role in insisting on higher levels of activity on behalf of Hispanic Americans, African Americans, and other race and ethnic communities and serving as a focal point for reporting and accountability.

3. We must support the integral role of community based non-profit, non-governmental service organizations.

This is especially true for the Hispanic community which does not have a network comparable in size, history, or resources as that provided by the Historically Black Colleges and the predominantly Black Colleges for the African American Community.

4. Support is required for service demonstrations, innovations, and redesign which emphasize integration of health and social services at the community level.

The response to the AIDS epidemic has demonstrated dramatically the wisdom, humanity, and efficiency of changing our pattern of delivering health care in isolation of social support. We are learning from the response to the drug epidemic, as well, that treatment for addiction is in many cases an extended process that only begins with medical and psycho-social interventions; it requires the mobilization of communities to help recovering addicts remain free of drugs and rebuild their lives.

5. Continued efforts to expand access to health care services for women and infants through the Medicaid program are required.

The high infant mortality rates for African Americans and the patterns of underutilization of prenatal care in Hispanic communities provide two compelling arguments for broadening access to Medicaid. In addition, the Medicaid program needs to develop greater flexibility in serving these populations, and to achieve this, additional funding for service demonstrations in the high-risk communities will be required. We know that the prenatal period and the first years of life play incredibly powerful roles in determining future health, learning ability, and psycho-social skills. The investment in health care, nutrition, and developmental services in the early periods of life are necessary, and they are fiscally responsible.

JAIME B. FUSTER
PUERTO RICO

WASHINGTON OFFICE:
427 CANNON BUILDING
WASHINGTON, DC 20515
(202) 225-2615

DISTRICT OFFICE:
P.O. BOX 4751
OLD SAN JUAN, PR 00902
(809) 723-6333

Congress of the United States
House of Representatives
Washington, DC 20515

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CHAIRMAN, HISPANIC CAUCUS

September 11, 1989

The Honorable Edward M. Kennedy
Chairman
Committee on Labor and Human Resources
Senate Dirksen 224
U.S. Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I would like to commend you for sponsoring the Disadvantaged Minority Health Improvement Act of 1989, an essential piece of legislation for the improvement of the health status of all minorities.

As Chairman of the Congressional Hispanic Caucus, I am extremely concerned about the health problems faced by the poor in this country, especially those of the disadvantaged patients within the Hispanic community. Unfortunately, the disadvantaged represent a large segment of the Hispanic community. Statistics show that almost one in four Hispanic families lives in poverty. (24.7% compared to 9.9% for non-Hispanic families).

More alarming, however, is the fact that Hispanics, although facing serious health problems as the result of poverty, are the group with less access to our health system and are dramatically underrepresented in the health professions, two important aspects addressed by this legislation.

Hispanics are the group least likely to have regular sources of health care with 30.1% of Hispanics lacking regular sources of health care compared to 20.1% of blacks and 16.3% of whites. Perhaps this alarming situation could be explained by the fact that even though Hispanics represent 7.9 % of the U.S. mainland population, Hispanics account for only about 4% of physicians and 2% of registered nurses.

The Disadvantaged Minority Health Improvement Act of 1989, if enacted, would provide new tools to address the health crisis facing our community. I am especially supportive of the bill's section which strengthens the mandate of the Minority Health Office of the Department of Health and Human Services to coordinate health prevention and service delivery programs within minority communities.

Moreover, this bill recognizes that an increase in financial aid programs for those interested in pursuing a health profession is essential if we want to increase the number of minorities in these fields. Thus, I am also extremely supportive of increasing the federal contribution to the Health Professions Student Loan Program in order to provide loans and scholarships to underrepresented members of minority groups.

I would like to point out that some Members of the Congressional Hispanic Caucus are actively working to address this crisis within our community. Representative Bill Richardson has been working in coordination with the late Representative Mickey Leland and Representative Louis Stokes and Senator Arlen Specter, in drafting the American Health Parity Act of 1989. This major piece of legislation addresses other issues of great concern to the minority community.

Examples of the issues we need to address are: reducing the infant mortality rate among minorities, increasing drug and alcohol addiction programs and extending pediatric AIDS services. I hope that all the members of the Congressional Hispanic Caucus will be called upon to provide support for this legislation.

Mr. Chairman, I would like to remind you that September 15th is the official commemoration of Hispanic Heritage Month, a celebration of the outstanding contributions of the 19 million Americans of Hispanic descent to the social, economic and political fabric of this Nation. It is also a month for reflection about who we are as a community and what we need to achieve and strive for in order to fullfil the American dream.

Thank you for your efforts to help Hispanics achieve these worthy goals.

Sincerely,

Jaime B. Fuster

Jaime B. Fuster
Chairman
Congressional Hispanic Caucus

The CHAIRMAN. Thank you very much for very good testimony on both parts.

Dr. Nickens, as a psychiatrist, could you comment on the impact of poverty, joblessness and homelessness on the high rates of intentional injury, teenage pregnancy, and drug abuse in the minority community?

Dr. NICKENS. Sure, I'd be pleased to.

I think that one of the things—and this is actually a very important question—because one of the things that is difficult when you talk about changing behavior is that people often tend to ascribe blame—that is, if you do something that is self-destructive, you deserved it. And there is a sense that people are all sort of born free and can choose to behave rationally or irrationally, destructively or constructively. And I think that it is very difficult many times for people to understand people who have grown up under poverty and discrimination.

What that does to people is give them a sense that they are not worth very much; they have a sense of anger toward the world; they have a sense that the future time horizon is probably day after tomorrow at best, and a sense that pleasures of today are really what you need to be concerned about.

What that can lead to is a lot of behaviors that middle-class and upper middle-class Americans may view as poor choices, but in the context of that oppression, if you will, seem rational choices. This has implications for all the diseases we are talking about, including AIDS.

So I think that we are going to have to do something about the overall sense of the hopefulness of life, what people have to live for. "Just say no" is not enough. You have to say "yes" to something, and the "yes" has to be something about your life chances. And that is why I put an emphasis on trying to do comprehensive programs and coordinating programs, because you can't just talk to a teenager about cancer or about AIDS or about substance abuse. You have to talk to them about their lives. And we need to do this better and better, and we haven't done it terribly well.

The CHAIRMAN. We hear a great deal of debate about increasing prison terms, stiffer sentences. And obviously, in some areas, they clearly should be increased. But in some of the minority communities, serving time in some instances is a badge of honor. They or their family, may still getting compensated from some of these drug dealers; they don't get very heavy lifting; and the drugs are better in prison than out in the street.

I found that to be mind-boggling. Does that have any ring to you?

Dr. NICKENS. Yes.

The CHAIRMAN. I would think most people, in this institution, certainly, would feel that that is a pretty far-out kind of condition. I mean, is it more real than we are aware of?

Dr. NICKENS. Yes. I think that if you can envision the kind of community that I just described with not very much that is positive going on, then prison is not necessarily all that bad in comparison. The other thing is that there was a study, for example, done in Washington, D.C. that showed that all the prisoners and all the guards basically came from the same neighborhoods, and so in a

sense it is almost as if the neighborhood has been transformed inside the prison or moved inside the prison.

So that again, I think we are going to have to find more comprehensive ways to deal with our inmate population around programs to try to do things around education, around self-concept—I mean, these sound like very mush, Sixties sort of words that no one talks about anymore, but the fact is, those things didn't go away——

The CHAIRMAN. Some of us still do.

Dr. NICKENS [continuing]. Yes, I know—those things didn't go away because they went out of style. And the fact is that most of the people in prison are poorly-educated, don't have a lot to live for, don't have many skills, and you are going to have to do something with that large percentage of people who are in fact salvageable. Now, there are some people certainly who commit crimes that are so heinous that they are not salvageable, but that is not the majority of prisoners in my experience.

The CHAIRMAN. Any insight in terms of the AIDS virus in minority communities?

Dr. NICKENS. I think once again, one of the things that has happened, of course, is that there have been outrageous amounts of moralizing around issues of AIDS.

The CHAIRMAN. Tell me about it.

Dr. NICKENS. And I think that with that as our national leadership, if you will, on this issue, then it is very difficult for local communities, local State health officers or local health officers, or community leaders to then advocate for being more liberal. In that sense it really does start at the top. So our national climate has been one of tremendous moralizing. That, somehow, we have to do a better job with. I'm not quite sure how, because clearly, you are talking about personal values of people who are in substantial positions.

The second issue is that we have to start accepting the fact that——

The CHAIRMAN. It starts out that this is a self-inflicted kind of disease and therefore we don't really have responsibility in dealing with it, and the way in which it developed was against the whole Judeo-Christian ethic. These are just some of the types of things we hear on the floor of the Senate.

Dr. NICKENS. Yes. And I think the other issue is that the cases arising fastest among those people who catch the virus from sharing of needles and so forth and heterosexual transmission, often a drug user having sex with either another drug user or a nondrug user and their having heterosexual transmission.

We are not going to be able to stop drug abuse fast enough to stop AIDS, and so I think we are going to have to reach into drug-using populations with very explicit interventions designed to at least stop AIDS. Now, some of that has started, but we have to get much more aggressive about that. And it is just not a matter of money; I think it is also a matter of being daring. And again, I think being daring works best if it is inspired from central leadership in Washington. Many, many groups look to Washington for the level of what is acceptable. So I think once again we need to inspire what is acceptable and send money. But just money won't solve it.

The CHAIRMAN. What is your own view about the needle exchange program. Have you taken a position on that?

Dr. NICKENS. Well, no one has asked me before publicly.

The CHAIRMAN. I want to see how daring you want to be.

Dr. NICKENS. This is not an official position. [Laughter.]

I think we have to try it. I think we have to try it and see how it works and evaluate it, and if it is a disaster, we can then stop it. But I think to just say it is bad and wrong and to assume that it encourages drug use, I think is overly simplistic. I understand that point of view.

I might add that one of the reasons why many people oppose needle exchange is not because they oppose needle exchange, but they think that needle exchange will then be used as a shortcut which will avoid all the other issues that need to be dealt with such as drug treatment and so forth. So they don't want to do that; they don't want to give someone an easy out.

The CHAIRMAN. OK.

Dr. NICKENS. I'd like to answer a question you didn't ask me but you asked others.

The CHAIRMAN. Good.

Dr. NICKENS. That was the question of how to attract more physicians to underserved areas.

The CHAIRMAN. Go ahead.

Dr. NICKENS. I have talked to a number of people about this, and I think that one of—I mean, it is an obvious solution—but I think that if we can pay differentials, differential pay, if you will, so that a person, rather than making what you would make as a standard community health center physician, let's say, that the Government or somebody would subsidize that to the tune of 50 percent higher, or 100 percent higher. Then I think you would attract people to inner cities. But if you were going to pay the standard wage that is paid, sort of what is really a base physician wage, people will always go to cushier areas unless they happen to have a personal commitment. And I don't think we can count on enough people with personal commitments to solve our health manpower problem unless we are going to have much, much higher rates of minorities in medical school than I think is possible now—and even then, that might not solve it.

The CHAIRMAN. OK. That is helpful.

Let me ask Dr. Delgado about some of the programs that have been successful, community-based health promotion and disease prevention activities. Do you know of some that have been successful and have made some impact—or perhaps you might be willing to take a look at it and advise us as part of your testimony. I am always interested in what is working and what has been successful, because it is useful for us in terms of making the case.

Dr. DELGADO. I think that most of the community-based funded programs that are run by people of that community tend to be very successful. And that sounds very simplistic, yet too often what we see is we see those large organizations who are not representative of African Americans or Hispanic Americans getting funded to do things in our community, and that creates problems of credibility, which is obvious, and also of real access to the community.

We have a host of programs like that that we are familiar with. There is a program called "A Su Salude", which is a major health promotion/disease prevention program in San Antonio, that was a research project; that is how it was intended, but in fact, it ended up being a major service to the community.

And throughout the United States, there are good models at the local level. The problem is when programs become too defined at the Federal level, not leaving that local community enough flexibility to decide what to do. We talked about flexibility for HHS; I want flexibility for that local community.

The CHAIRMAN. Good. And particularly now in those community health centers, they are so overburdened, with so many new challenges, too; it is awfully difficult for them to develop new programs and put the resources into them.

In New England, the greatest growth in terms of HIV infection has been within the Hispanic population. I guess this is also true in East Harlem, and East Los Angeles. I don't know whether you might be able to comment on that.

Dr. DELGADO. Well, part of the problem is if you only go through health agencies to provide health information to a community which doesn't have access to health care, you are going to have problems reaching them. So that is what has happened too often. So health information, be it about AIDS, diabetes, cancer or whatever, has typically gone through agencies which don't reach our communities.

So very often the people that we work with are community service agencies where they develop the health component, because the agencies have credibility, they have access to the people and will actually get out to the streets and give the information which is necessary.

So I think you have to rethink what each agency does. The community health centers are wonderful, but as you said, they are way overextended in both their responsibilities and in the needs of these communities that they serve.

The CHAIRMAN. Well, maybe you could take a look at the legislation and the existing programs, and maybe there is something in this legislation that we might be able to sharpen that up a bit; we'd be glad to take a look at it. I think there is a lot to what you say.

Dr. DELGADO. I just wanted to add something—it was a question you asked Dr. Nickens, but I wanted to respond.

The CHAIRMAN. Please, go ahead.

Dr. DELGADO. You mentioned about person in prisons. Just two things. One thing which you said about Hispanics and African Americans is true for anybody involved in the drug industry who is in jail. They do have special protections and things like that, regardless of your color tone.

The second thing is that COSSMHO, the Urban League and the Humphrey Institute did a study of incarceration rates of Hispanics and African Americans, and we found that our kids tended to be incarcerated much more often than other kids who are nonHispanic, white, who have committed similar crimes.

So another thing is happening which is important—that our kids do the same thing, but they don't end up in the alternative treat-

ment centers. So there are many things going on in our communities.

The CHAIRMAN. Well, I couldn't agree with you more. I was the author of the Sentencing Reform, and at the Federal level they are supposed to be getting comparable time for comparable crime—with certain very limited exceptions both above and below that, such as aggravating or mitigating circumstances—we just got that at the Federal level. But example after example—kids do one thing in New Bedford, another in New River—entirely different sentences. And we now have one or two States that have accepted that, with regard to white-collar crime. I mean, someone shoplifts versus someone who takes all of City Hall, and they are treated entirely differently, and kids wonder what is the sense of justice. So I hear you on that.

And of course, with all the talking about what we are going to do with regard to drugs, at the Federal level we treat about 11 percent of the inmates for drug addiction; the States treat on average 22 percent. My own State is about 35 percent. And the tough guys who come through the system, they come through time and time again and have this addiction. But the basic problem that we are facing is if you have limited resources for treatment, people are going to say, well, let's take care of the people outside of jail rather than the people who are in jail. But if you are interested in crime in the streets, maybe you'd think about trying to do something for the people who are in jail—or at least try and do both, if you are going to begin to get serious about it.

We are dealing with all these symbols and impressions, and I think to a great extent it is stimulated by the sense of legitimate concern about violence and security in the communities—and obviously, there are a lot of other reasons as well.

This has been very useful. If anybody can think of another question that I haven't asked and they want to answer, I hope they will submit it for the record. I do want to thank you—

Dr. DELGADO. Yes, one more—self-inflicted—cancer through smoking, diabetes through obesity—all those and most of our diseases can be seen as self-inflicted. Personal behavior has a lot to do with illness—having just lost a lot of weight myself, I can tell you it is hard to change behavior—but that is where we have to go to the society. So when people bring that up with AIDS, I think we have to look at the broader picture and say that we have to take care of ourselves ourselves.

The CHAIRMAN. Which diet do you use. [Laughter.]

The committee stands in recess.

[Whereupon, at 4:00 p.m., the committee was adjourned.]

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